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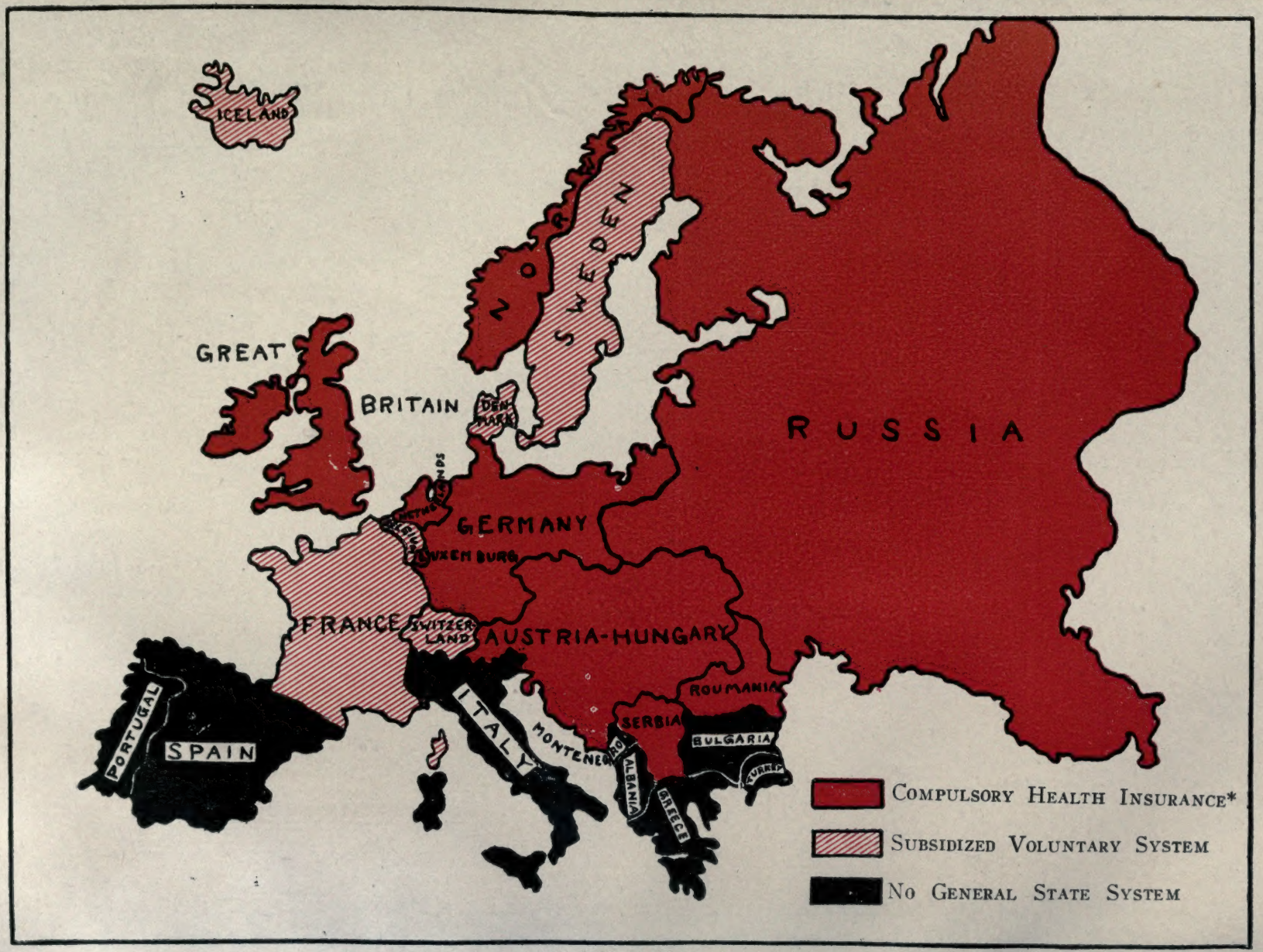

HEALTH INSURANCE IN EUROPE

*NOTE:—Compulsory health insurance also exists in Italy for maternity cases and for railroad employees, in France for miners and seamen, in Denmark for alien seasonal workers, and in Switzerland in several cantons.

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Social Insurance Committee

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The American Labor Legislation Review

JOHN B. ANDREWS, Editor SOLON DE LEON, Assistant Editor

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CONTENTS

I. Is Health Insurance "Paternalism"?
WILLIAM HARD 123

II. Compulsory Health Insurance in Great Britain
OLGA S. HALSEY 127

III. Tendencies in Health Insurance Legislation
MARGARETT A. HOBBS 138

IV. Voluntary Health Insurance in New York City
ANNA KALET 142

V. Brief for Health Insurance 155

VI. Health Insurance Standards 237

VII. Tentative Draft of an Act 239

VIII. Select Critical Bibliography on Health Insurance..... 269

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seamen, in Denmark for alien seasonal workers, and in Switzerland in several cantons.

COMMITTEE ON SOCIAL INSURANCE

OF THE

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INTRODUCTORY NOTE

The public issue now uppermost is National Preparedness. To many it means millions for munitions. To others who realize the fundamental need of efficiency through industrial training and organization it is beginning to offer a vision of millions of men and women fit for the nation's service in times of peace no less than in the occasional time of war.

Generalities and sounding phrases in the name of "social justice" are not satisfying. Something more specific that can be put into operation is required if we are to bring about the development and maintenance of American standards worth fighting for. One of the immediate steps in such a concrete program is Health Insurance.

In December 1912 the American Association for Labor Legislation created the Social Insurance Committee which is pointing the way toward definite and practical preparedness against industrial sickness. Its aim has been to study conditions impartially, to investigate the operation of existing systems of insurance, to prepare carefully for needed legislation, and to stimulate intelligent discussion. In the spring of 1913 it organized the first American conference on social insurance; in July 1914, after much discussion and revision of proposals, it formulated a tentative statement of the essential "Standards" which it purposed to

follow. Criticism received from physicians, employees and employers throughout the three and one half years of the committee's work was of the greatest assistance in formulating the tentative "Draft of an Act" for insurance against sickness which was first published in November 1915 and, with some elaborations, has already been introduced in Massachusetts, New Jersey, and New York. Meanwhile investigating commissions in California and Massachusetts have been created to report in January 1917 when bills for compulsory health insurance will doubtless be before the legislatures of the principal industrial states.

In the preparation of the material for this special edition of the REVIEW members of the committee and of the office staff of the Association have attempted to present facts which will be of assistance to every state in the campaign which is but begun.

JOHN B. ANDREWS, Secretary
American Association for Labor Legislation

123

IS HEALTH INSURANCE "PATERNALISM"?

WILLIAM HARD

In the city of Leipzig there is an institution which is sometimes said to be the finest specimen of Paternalism in all Germany. It exercises a stern jurisdiction, in matters of sickness, over some 200,000 wage-earners in Leipzig itself and in various adjoining districts. Whenever any one of its subjects falls sick, it sends a listed and guaranteed doctor immediately to his bedside. At the same instant it rushes medicines to him from a listed and certified drug store. It cures him in his home, if it can. If not, it drags him to a hospital and goes at curing him there. If, anyway, he dies, it provides money for his funeral. These things—and many others—it does (just as similar though smaller institutions all over Germany do) under general orders directly from Berlin.

Still, I should hesitate to say that this institution—the Federation of Leipzig Sick Funds—is "philanthropic" in the cordial American sense of the word. In our large cities every year large numbers of wage-earners get medical advice and medical treatment from Visiting-Nurse Associations and from private and public dispensaries and from private and public hospitals without paying for any of it at all. They get it totally free. That is philanthropy. Some people might even call it Paternalism. The case of the wage-earners of Leipzig is brutally different.

All Leipzig wage-earners, coming within the jurisdiction of the Federation of Leipzig Sick Funds, are compelled by the Imperial Government to pay weekly, out of their own pockets, a certain tribute to the Federation's treasury. This tribute amounts to two-third's of the Federation's running expenses. It is a stiff blow. Yet the Imperial Government remains unsatisfied. If those wage-earners paid that money and got that medical care and did nothing more, they would be merely passive recipients of welfare. The

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[1] Extract from article "Who Keeps the Watch on the Rhine?" Reprinted by special permission from the *Metropolitan Magazine* of March, 1916.

Imperial Government is determined that they shall be active dispensers of welfare. Thereafter, further, from their own number, they must elect two-thirds of the members of the "Committee" by which the affairs of the Federation are in general supervised; and these members of the "Committee" must choose two-thirds of the members of a second body called the "Directorate," by which the affairs of the Federation are immediately managed; so that the supervision and management of the Federation shall rest principally with the wage-earners themselves.

The Federation of Leipzig Sick Funds spends $1,750,000 a year. Where, among us, is there so spacious a social-welfare institution operated under the daily control of wage-earners?

The farmers of Arheilgen are encouraged toward Self-Help. The wage-earners of Leipzig—and of all other places within the Empire—are coerced into it.

The employers are coerced into it, too. They must pay one-third of the running expenses of all Sick Funds in all localities and they must elect one-third of the members of the "Committees" and of the "Directorates."

These elections are particularly coercive for the persons elected. If you are an employer and you are honored by your fellow-employers with an election to the "Committee" or to the "Directorate," you may be a very busy man, with large business interests, but you have only five chances of escape. They are laid down for you in Article Seventeen of the Imperial Insurance Code. You may show that you already have more than one guardianship or trusteeship. You may show that your only employees are domestic servants. You may show that you are sick or infirm. You may show that you have more than four legal children under age (it being assumed apparently that such a domestic man should not be torn from his home). Or you may show that you are past sixty. If you cannot make any one of these showings, you serve. And if you neglect your duties, the chairman of the Directorate fines you, from time to time, up to a hundred marks, under Section Nineteen.

At this point the bureaucrats of Berlin retire to their caves and compile statistics and grin at their victims. They have got a lot of private citizens into doing a lot of public work. Is it not the work of the state to look after the sick poor? Why else do we permit

long lines of the penniless at the doors of our public dispensaries and fill our public hospitals with no-pay beds? Certainly it is, in part at least, the work of the state. And see those citizens doing it! And with such zeal! They actually, in many cases, go far beyond the general orders of the Insurance Code in their care for their sick, at their own additional expense!

In Leipzig, for instance, if a garment-worker, affected by confinement and bad air, is sick with general nervous collapse, there are special arrangements ready for him which the general orders do not at all require. His doctor may take him to a laboratory, owned by the Federation, where there are Solar Baths and the like. He may take him afterward to another laboratory, owned by the Federation, where there are Swedish Zander mechanical treatments. He may send him finally to a sanatorium, owned by the Federation, in the open country, expressly for nerve cases. The general orders do not say that the Federation shall own any such laboratories or any such sanatorium. It is Leipzig, it is the local management, that wishes them.

Leipzig also wishes, and has, a large number of beds in four open-country sanatoriums for ordinary convalescents. It also has two special forest resorts for consumptives.

The general orders say that a man sick at home shall have, besides medical care, a "pecuniary benefit" amounting to fifty per cent of his former daily wages. Leipzig makes it fifty-five. The general orders say that he shall continue to have this "pecuniary benefit" for twenty-six weeks. Leipzig makes it thirty-four.

Having got started, it goes forward. Having been coerced into self-activity, it self-acts beyond coercion. It does this not only in the way already mentioned but also in another way which reflects even greater credit on the labor-saving instincts of the officials of the Imperial Government.

If you simply pass a law saying that all tanneries shall be sweet and wholesome places, you give yourself a task which you cannot discharge except with the help of a mob of inspectors—a method meaning endless toil and costing you much money. How much easier, how much more economical both of your moneny and of your time, to erect a nice little automatic machine which, without your being there at all to tend it, will slap the tannery-proprietor at

frequent intervals and will make him immediately, on his own account, on behalf of his own pocketbook, meditate on sanitation and admire it and yearn for it.

The Sickness Insurance machine makes him yearn for it every time he sends his enforced contribution to his local Sick Fund—which is at least once a month. "That sickness rate is getting to be terribly high," says he. "The premiums we have to pay are awful. This town is loaded with sickness. Everybody is sick. Why doesn't somebody do something about it? Cut down the sickness. Cut down the cost. The Mayor ought to do something about it. Look at these statistics! Ah! Tanneries! Grippe! Rheumatism! Pneumonia! Boy," says he, "is that fellow still in the building that tried to sell me that fool scheme for keeping tanneries dry? I think I will see him."

Berlin was right. That little monthly Sickness Insurance premium has been worth thousands of sanitary inspectors to the Imperial Government. It is paid now by virtually all employers. The number of insured wage-earners reaches 19,000,000. Their employers all pay; and they pay more when sickness is high and less when sickness is low. It is not without sound reason that sanitation has become a holy passion in the minds of multitudes of the more intelligent among them.

COMPULSORY HEALTH INSURANCE IN GREAT BRITAIN

OLGA S. HALSEY
Special Investigator, American Association for Labor Legislation[1]

The right of a government to coerce its citizens into insuring for those contingencies against which experience has proven that they are unable to protect themselves has been asserted not alone by Great Britain's Prussian enemy and eight other European nations, but by democratic and individualistic England herself. The presentation of a bill for compulsory health insurance to the British Parliament in 1911 was the more remarkable since 5,500,000 of the more thrifty British workmen were then voluntarily insured against sickness through friendly societies and trade unions. This voluntary insurance, however, did not provide for those who most needed it—the less thrifty, the more poorly paid, those to whom sickness was a greater disaster—who are now included within the compulsory system. To these 8,000,000 workers the only assured protection was that offered by the charitable societies and the poor law with its hated stigma of "pauper." To the British this provision seemed wholly insufficient, and under the commanding leadership of Lloyd George a bill for compulsory health insurance embracing all workers was introduced into Parliament in May of 1911. It was passed the following December, came into operation in July of 1912, and six months later benefits became payable.

Included within this "national health insurance," as it is termed in Great Britain, are all persons between sixteen and seventy employed for remuneration under any form of contract, if engaged in manual labor or if the rate of their annual earnings is less than $800. Within this classification numerically unimportant exemptions of individuals or the exclusion of occupations may be granted by the commissioners for reasons established by the act. Untouched

[1] Miss Halsey spent nearly a year in England studying the operation of the national insurance system.—EDITOR.

by its compulsory provisions are all those working independently—the small shopkeeper, the village carpenter or the cobbler, all of whom have no employer and whose insurance would be difficult to enforce. Those employed within the meaning of the act and insured during the first year, 1912, numbered 13,472,000, or nearly 30 per cent of the total population.

The benefits to which these 13,742,000 workers are entitled include medical care, sanatorium treatment if attacked by tuberculosis, a cash benefit at the time of childbirth, a weekly payment during twenty-six weeks of illness in a year and a smaller weekly sum during prolonged disability.

The medical benefit guaranteed to each person insured for half a year consists of medical treatment, medicines, and specified appliances. This benefit is administered by insurance committees which are appointed for definite areas to represent insured persons, doctors, and the local government of the administrative district. These committees arrange for the medical care of the insured workmen in accordance with regulations of the central administrative body, the insurance commission, and then draw up a list or "panel" of physicians who have agreed to the terms. These arrangements must observe two fundamental conditions; first the right of every duly qualified physician who wishes to serve upon the panel to be placed upon it, provided he is not proven injurious to the service; and second, the right of each insured person to select his physician from among those on the panel. For the remuneration of physicians a minimum of $1.68 and a maximum of $1.80 is annually set aside for the medical care of each insured person, regardless of the amount of medical attention he may require. This sum, exclusive of the cost of drugs and appliances, is nearly twice the average physician's income before the insurance act, estimated upon the basis of per capita of the population. Under these conditions, about 20,000 doctors in England, Scotland, and Wales have undertaken insurance practice. This in various districts represents from 70 to 100 per cent of the medical profession practicing among the industrial population.

Sanatorium benefit for the tuberculous insured is provided through the insurance committees which make arrangements for sanatorium treatment with the local authorities.

A weekly sick benefit for a maximum of twenty-six weeks in a

year is granted to each insured person not over seventy years of age who has paid twenty-six contributions, and who produces a certificate from his panel doctor that he is incapable of work. Ten shillings ($2.40) a week for men, and seven shillings six-pence ($1.80) a week for women is the legally established benefit paid by each society approved under the act.

A disablement benefit of five shillings ($1.20) a week is paid to both men and women, insured for two years, when the illness extends beyond the twenty-six weeks covered by sickness benefit. This payment continues for the entire duration of the incapacity, and ceases only when the insured reaches seventy, when an old age pension of equal amount is due him under the old age pensions act.

The maternity benefit of $7.20 (exclusive of medical attendance) provided for the wife of each insured man as well as for each insured woman is one of the most popular and the most easily administered features. This payment, made solely to help defray the expenses of confinement without regard to incapacity either before or after, is to be distinguished from sickness benefit. Indeed the receipt of a maternity benefit debars the insured mother from the right to receive sickness benefit for the four weeks immediately following confinement.

The cost of these five benefits involving a large total annual expenditure is divided among the worker, the employer and the state. Each insured man pays 8 cents weekly, an insured woman 6 cents, the employer 6 cents weekly for each employee, man or woman, while the state contributes an additional 4 cents. With the exception of the low paid worker earning less than at the rate of 60 cents a day, for whom the employer and the state pay a larger proportion of the contribution, this rate is uniform for all age or wage groups and for all occupations, regardless of the sickness hazard of the industry.

This flat rate contribution, a distinguishing feature of the British system, is based upon the cost of providing a person of sixteen with all the benefits until seventy, and with medical and sanatorium benefits throughout life. It allows for the heavier claims of later life by charging the person of sixteen more than his benefits at that age actually cost. By this method a reserve is accumulated from which the claims of middle life may be met. To estimate this cost the sickness tables of the Manchester Unity—one of the old and well managed friendly societies—were used after they had been adjusted to allow

for a different distribution of age, occupation, and civil status among the compulsorily insured population. In this calculation it was assumed that each of the approved societies carrying insurance would have its fair proportion of the average distribution of risks, and that no one society would depart radically from the average in age distribution, in occupational hazards represented, or in proportion of married and unmarried members. The actuaries, however, were unable to find any suitable table for women, and according to their own admission they used the adjusted Manchester Unity table "without modification" to measure the probable rates of sickness among women. Upon these assumptions the attempt was made to determine once for all the liabilities of this gigantic new system of national insurance, and to fix a uniform contribution which would be sufficient for future expenses among all societies.

A uniform contribution for the various ages entering insurance at the inauguration of the system was possible only by crediting to those over sixteen the amount which, had they been insured from the age of sixteen, would have accumulated to their credit to pay for the heavier claims of old age. Accordingly a "reserve value" was credited to each person over sixteen included within the act, making an aggregate total of $432,000,000. This huge sum at first appeared only as a book credit. To convert this into cash and at the same time to provide interest on the capital sum, nearly one-fifth of each week's contribution is diverted to writing down the reserves, a process which it was originally estimated would require eighteen to twenty years. When the reserves have been converted into cash, the released one-fifth may be used for increasing the benefits established in the present act.

The financial side of the act centers around the approved societies which are the real carriers of insurance, paying cash benefits to their members and reimbursing the insurance committees for expenditures connected with medical and sanatorium benefits.

The approved societies, of which there are 23,500 independent societies, lodges, and courts, are in some cases the old friendly societies approved for the purposes of the act, some have been organized by trade unions, and still others are special societies modeled after the friendly societies and organized to administer national health insurance. Following the prerogative of the friendly society each insured person is given an unrestricted right to select

his society, and each society may reject an applicant on any ground save that of age. Thus it may limit its membership to those who are members of a trade union, to those who are engaged in a particular occupation, or to total abstainers, etc. The great discretionary power given to the societies to administer their own affairs is a keynote of the British system. In theory each society of over 5,000 members is financially independent, its solvency depending upon its own successful administration. If the expenditure is in excess of the actuarial expectancy, a deficiency will result which the society must make good, either through a levy upon its members or by a reduction in its benefits. Temporary provisions for persons who might be refused and for those not desiring to join a society were supplied by the "deposit contributors' " fund, under the control of the insurance commissioners.

A segregation of the insured persons by trade has in some cases resulted from the freedom of the insured to choose his society and from restrictions placed upon membership by the societies themselves. In the words of the interim report of the departmental committee on approved society finance and administration, "Insured persons were allowed, were indeed urged, to segregate themselves into societies that seemed to promise satisfactory results, and the prospect was held out to them that they would derive a direct benefit from the wisdom of the choice of a society. In other words, Parliament contemplated in one fundamental aspect a departure from the fundamental working of a flat rate system." This trade segregation, whether a favorable one as in the case of bank clerks and domestic servants, or an unfavorable one as in the case of cotton mill operatives, miners and boot and shoe workers, carried with it the isolation of trade risk far below or far above the average occupational hazard for the entire insured population for which the flat rate contribution was calculated. The uniform contribution calculated for the average is frequently insufficient for the worse risks, and a society may therefore be threatened with a deficiency, since each is financially independent and is unable to benefit from the surplus of another having a more favorable selection of members. The deficiency from this cause actually threatening some societies has proven a serious matter to two departmental committees. The recommendations of both were the same: namely that a portion of the reserve fund be set aside to form a "special risks fund" from

which societies having an unfavorable selection of lives might recoup themselves. This assistance to individual societies is necessary even though the sickness benefits for men, taken as a whole, are within the actuarial expectation.

Moreover, a variation from the normal distribution of women has presented grave financial questions to other societies. The sickness rates for women, it has been pointed out, were assumed, in the absence of other evidence, to be the same as those for men. Experience has shown that sickness among single women is in excess of the expected rate, while that of married women is even more excessive. This means that the women are now receiving more than their contributions entitle them to. To remedy the situation, contributions should be increased, or the benefits reduced. This fundamental remedy has been shunned by two departmental committees in succession, and the same solution has been proposed by both,—that of diverting part of the reserve funds to supply the immediate needs. To meet the more numerous claims of married women, due in part to the demands for sickness benefit during pregnancy, unforeseen by the actuaries, still a third invasion upon the reserve funds, coupled with a parliamentary grant, is contemplated by both committees.

In contrast to this segregation, a widely scattered membership without geographical or trade grouping may result from the same freedom in selecting a society. This situation, though unaccompanied by the same financial dangers, has its grave disadvantages. For example, because the members of a community or industry are insured in hundreds or even thousands of societies with other persons, it is difficult to discover an excessive amount of sickness for that group. Without this knowledge it is of course more difficult to take preventive steps. Moreover, a membership distributed throughout the entire kingdom has materially hindered the development of anything like an effective system of sick visiting; it is even a question with one society actually insuring millions of workers, whether a complete system, reaching out to the tiny isolated villages, will pay for itself. Without such a system, the ratio of unnecessary claims will be somewhat higher than when they are closely watched as they can be with a concentrated membership.

The conclusion to be drawn from this British experience with a flat rate contribution and with free choice of carriers is twofold. First,

the two when dependent on each other are undesirable. A flat rate contribution is clearly impossible when there is unrestricted freedom in the selection of the society, because of the segregation of special risks which may and does result. Second, even if the flat rate is not combined with choice of approved society and if all possibility of segregation of risks is eliminated by prescribing the carrier, a flat rate is still undesirable. First, it is impossible to foretell accurately the liabilities even upon the most accurately prepared sickness data. The error in the sickness rates of women made by the British actuaries is an example. Secondly the contribution is regarded as permanent by the contributors and any attempt to change it is resisted. Hence, as in Great Britain, initial mistakes in the financial estimates must be rectified from some other source. The same opposition to any increase in the contributions has been manifested when the purpose has been to increase the facilities of the insurance system. As a result such additional expenditures have been met by parliamentary grants when as a matter of justice the increased income should have been derived from the insurance payments. The system of free choice of carrier, even if unaccompanied by a flat rate contribution, is in itself undesirable. The same segregation of membership might well result, involving a higher contribution to cover the experience of individual funds. Where many employees in a plant were insured in as many societies, there would be dismay upon the part of the wage clerk in setting aside the correct contribution for each man. This mechanical difficulty might well be an incentive for the employer to maintain his own establishment fund. Moreover, the difference in the weekly contribution, assuming it made a difference to the employer as well, might well lead him to discriminate in favor of the most economical fund. Such a development would render freedom of choice chimerical. Furthermore, the system as a whole would be crippled if it were unable to ascertain in which trades and localities the sickness rates were highest, and if, for lack of this knowledge, it were unable to call attention to the excessive sickness and to take active steps for its prevention.

The financial difficulties facing the British system, it is important to bear in mind, are due to the attempt to forecast once for all time the cost of the insurance, in which the government actuaries failed; and secondly to the iron clad nature of the contributions and benefits which preclude every effort to obtain additional income

from this source. These are defects which the flexible average premium system adopted by the German act and in successful operation now for more than a quarter of a century has been able to avoid.

The administration, aside from that of the approved societies which has just been considered, rests with the insurance committees and the central insurance commissioners. The administration of medical and sanatorium benefits, although duties naturally falling upon the approved societies, have been farmed out to the insurance committees because of the greater ease in administration when the membership is localized. The insurance committees, which require duplicate records, increase the staff of workers, and thus add to the cost of administration, are a cumbersome effort to provide for local administration, the principle of which has been violated by the present organization of the approved societies.

The central administration is entrusted to four commissions, one for each of the four countries, England, Ireland, Scotland, and Wales, and a joint committee which coordinates their activities. It is these five bodies, jointly referred to as the commission, which make the extensive regulations for the administration of the act, and which supervise the approved societies and insurance committees, endeavoring as far as possible to make the practices uniform throughout the kingdom. Here too there is unnecessary duplication in administrative force, necessitated by the strong feeling for "home rule" which is not confined to Ireland alone.

Notwithstanding, however, the unfortunate system of finance and of administration which have been adopted, the beneficial effects of the act are quite evident. During the first year of benefits (January, 1913-January, 1914) 3,600,000 persons are calculated to have had sick benefit, or about 25 per cent of those insured, an experience which roughly corresponds with the financial estimates. This has involved an expenditure of $30,000,000 for the entire kingdom. The disablement benefit which really covers permanent invalidity was expected to involve an expenditure of $9,700,000 in 1915, thus increasing by one-third the amount spent in sickness benefit. Its financial success, for which there were many fears before it came into operation in July of 1914, is revealed in the recent interim report of the departmental committee on approved society finance and administration. The committee states that during the first eighteen

months the expenditure was within the actuarial expectation for that period, but that in the future it is possible that the disablement benefit for women and especially for married women may involve a heavier charge than originally anticipated. The combined effect of the medical care and the provision of cash benefit is that many who previously had dragged along without medical advice, forcing themselves day by day to work in spite of illness, have now for the first time had proper attention. Physicians have said, "I thought I knew how much illness there was in my neighborhood, but I had no conception of the amount that existed until I was brought in contact with it through the act . . . I had no idea that it existed, and was going unrelieved, and that people were dragging along with such illness." An official investigating commission states that "already there are indications that as a result of the rest obtained under the act a better condition of health has in certain cases been attained than has been experienced for many years."

The maternity benefit, it is calculated, went each week of the first year to 17,000 mothers and throughout that year 887,000 received maternity benefit, involving a total expenditure of $7,000,000. The results of the cash maternity benefit were soon discernible in the rapid decrease in the mothers seeking assistance from the out-patient departments of hospitals and from other maternity charities, and in their willingness to pay for what previously had been given to them, sometimes engaging a member of the hospital staff, but more frequently resorting to the midwife who often could be prevailed upon to give needed help with household duties. This increased use of the midwife, trained and supervised though she be as in England, creates a new problem which can be solved only by providing the maternity benefit in much the same way as medical assistance is now provided for insured persons.

The effect has also been felt by poor law officials and charity workers. The poor law has been relieved of a large number of calls for medical care from the parish doctor, for midwifery assistance and for out-door relief in time of sickness. In the towns of Bristol and Manchester the diminution in pauperism in 1913 as compared with 1912 is attributed to the insurance act; in the latter city the number of payments of out-door relief decreased by 30 per cent, while the actual amount diminished 25 per cent. Among the Liverpool dock laborers it is estimated that in half the cases which re-

ceived sick benefit, the home would have been broken up and relief sought in the workhouse had it not been for the benefits of the insurance act. Charity workers, too, have found that the calls for financial relief have diminished both in number and in the amount of assistance required. On the other hand, some of the local poor law officials fear that the enlarged use of doctors brought about by the insurance act, which is revealing a larger number needing hospital care, may increase the inmates of the poor law infirmaries. This, of course, is significant of the higher standard of medical care for the working man resulting from the insurance provisions. Sanatorium benefit, notwithstanding petty jealousies between rival local boards, fostered by the administrative system, and the inadequate funds at the disposal of the insurance committees for their share of the work, was received by no fewer than 44,000 insured workers in the first eighteen months' operation of the act. Of this number, more than half were placed in sanatoria, others were treated in dispensaries, and still others were cared for in their homes by the panel doctor, under the guidance of the tuberculosis officer. To assist in home treatment 1,200 shelters for out-of-door sleeping were available, and in other cases milk and eggs were supplied to patients in their homes.

Moreover, the whole anti-tuberculosis movement has been strengthened. To provide the additional sanatoria necessary for the treatment of the insured and their dependents provided for in the act, Parliament in 1911 made a grant of $7,200,000 to defray part of the expense of sanatoria whether erected for insured or non-insured. Under this generous provision plans for 3,000 new beds had been made within the first twenty months and grants to the extent of $1,287,000 had been either made or promised. Following the recommendations of the famous Waldorf Astor committee that sanatorium benefit should be available not only to the dependents of insured but to the whole population, the government announced in July of 1912 that it was willing to bear one-half of the expense incurred by the local authorities in treating non-insured persons as well as the dependents of insured workers. For this purpose Parliament granted $1,464,000 and $2,300,000 for the budget years of 1914 and 1915 respectively. The provisions which have thus far been made are but the beginning of an effective crusade against tuberculosis, instigated by the insurance act and originally restricted to the insured and their families but later extended to the entire population.

If even a cumbersomely conceived plan of health insurance can improve health, decrease pauperism, and forge an effective weapon against tuberculosis, are not we Americans challenged to devise a system which will function more perfectly in our war against poverty and disease?

TENDENCIES IN HEALTH INSURANCE LEGISLATION

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The five years between 1909 and the outbreak of the European war saw rapid development in compulsory health insurance legislation. During that time such laws were adopted by the six countries of Norway, Roumania, Russia, Serbia, Great Britain and the Netherlands. The four countries of Germany, Austria, Luxemburg and Hungary had previously passed such compulsory laws.

All the laws cover practically all low-paid wage-workers. In the Netherlands and Norway workers receiving less than a given income are included, without regard to occupation, while the Standard Bill of the American Association for Labor Legislation, like the laws of Austria, Germany, and Great Britain, applies to all manual workers and to other low-paid employees. The laws are equally inclusive in covering all forms of sickness, while in Austria, Germany and Norway, the first few weeks of industrial accident disability also are compensated from the health insurance funds.

The benefits provided are of two sorts—medical assistance and cash payments. The Standard Bill follows prevailing European standards by granting the latter for twenty-six weeks, dating from the fourth day of disability, while medical attention is supplied from the beginning of illness as long as cash benefits are due. In most European laws these are only the minimum terms for benefits, however, and higher standards are permissible. Thus in Germany the waiting period may be shortened or entirely eliminated and under some additional restrictions benefits may be paid as long as fifty-two weeks.

The laws fix the minimum rates for cash benefits, but frequently allow higher rates as well. Minimum rates in Austria, Germany and the Netherlands vary from 50 to 60 per cent of wages, while a maximum of 75 per cent is permitted in Germany and Austria and 90 per cent in the Netherlands. England is the only country paying uniform benefits without regard to wages. The standard of the Association bill, 66 2/3 per cent of wages, is that of the best American compensation laws and falls between the extremes of European legislation.

The laws usually provide insured persons not only with medical treatment, but also with medicines, therapeutic appliances and, except in England, with hospital care. In England, however, provision is made for all forms of tuberculosis, which are entitled to sanatorium care. Medical care to the dependents of the insured, which permits economical medical service and adds much to family well-being, is optional in Austria, Germany and Great Britain and compulsory in Norway and in the Standard Bill. While no medical benefit is furnished in the Netherlands, the deficiency is partly made up by the high rate of cash benefits, usually 70 per cent of wages, and by the numerous voluntary "sick clubs," which must be open to any insured person.

Maternity benefit is provided in every European law. The insured woman usually receives obstetrical assistance and a cash benefit for four or six weeks at her confinement. Great Britain, conforming to the flat rate principle, gives a lump sum of $7.20 both to insured women and to the wives of insured men. The latter receive obstetrical care under the terms of the Standard Bill, and in Germany such care and also pregnancy and nursing benefits may be furnished.

European legislation empowers the insurance carrier to make contracts with physicians for medical service. Perhaps the most common arrangement is that of England and Germany, by which free choice among a panel of physicians is normally allowed. The four options of the Standard Bill, namely, choice among a panel of physicians, "reasonable free choice" among salaried physicians, district medical officers, or a combination of these methods, permit an adjustment to local conditions of the plans found successful in European experience.

A modest funeral benefit, large enough for decent burial according to prevailing standards, is also provided by all the laws except those of England and the Netherlands. In Austria, Germany and Norway an allowance of from twenty to fifty times the average daily wage is made; the Standard Bill fixes a maximum of $50.

The cost of health insurance is in every case met by joint contributions. These come in Austria and Germany entirely from employers and employees, but, under the other laws and the Standard Bill, from employer, employee and the government. England accompanies a flat rate of benefits by a flat rate of contributions; other countries and the Standard Bill vary the contributions according to wage.

In its administrative machinery the Standard Bill follows closely the provisions of all the laws considered except the British. The normal insurance carrier it sets up is a district local or trade fund under mutual management, but such other societies as establishment funds, labor union funds, and the like, may, with permission from the supervising authorities, also carry the insurance. In every case the "approved societies" must be mutually managed and cannot be profit-making enterprises. In Great Britain, where no district funds are established, and "approved societies" may contain members from any locality, there has resulted a clumsy and unsatisfactory division of authority by which cash benefits are paid by the societies, while medical benefit is administered by local insurance committees.

The "mutual management" of the district funds is that of employer and employee, with, in some cases, as in Norway and the Netherlands, representatives of the government also. Employees have a majority representation in Austria, Germany and Norway, and British "approved societies" are entirely controlled by their members. In the Netherlands and in the Standard Bill employer and employee are given equal representation. In every instance there is government supervision of the funds.

TENDENCIES IN HEALTH INSURANCE LEGISLATION

This table presents only the main features of leading health insurance laws, omitting numerous minor qualifications. Most of the European countries mentioned have, in addition to workmen's compensation for accidents, and health insurance, provisions for the contingencies of invalidity, old age, and unemployment.

	Germany (*Adopted* 1883; *in effect* 1884; *recodified* 1911)	**Great Britain** (*Adopted* 1911; *in effect* 1912)	**Austria** (*Adopted* 1888; *in effect* 1888)	**Netherlands.** (*Adopted* 1913; *in effect* ——?)	**Norway.** (*Adopted* 1909; *in effect* 1911.)	**Standard Bill American Association for Labor Legislation**
Scope of Compulsory Insurance	1. All manual employees. 2. Other specified employees (foremen, officials, clerks, teachers, actors, musicians) receiving less than $600 yearly.	1. All manual employees between 16 and 70. 2. All other employees between 16 and 70 receiving less than $768 yearly.	1. All wage-earners (agriculture, forestry, and homework excepted). 2. All administrative officials receiving less than $480 yearly.	All employees receiving less than $300-$600 yearly according to locality (domestic servants, certain casual employees, and certain taxpayers excepted).	All employees over 14 receiving less than $324-$378 yearly according to locality (certain casual employees excepted).	1. All manual employees. 2. All other employees receiving less than $1,200 yearly.
Disabilities Covered	1. All sickness. 2. First 13 weeks of industrial accident disability.	All sickness and accidents not covered by workmen's compensation or common law.	1. All sickness. 2. First 4 weeks of industrial accident disability.	All sickness.	1. All sickness. 2. First 4 weeks of industrial accident disability.	All sickness, accidents, and death, not covered by workmen's compensation.
Waiting Period	1. For cash benefit: up to 3 days. 2. For medical benefit: none.	1. For cash benefit: up to 3 days. 2. For medical benefit: none.	1. For cash benefit: none, if illness lasts more than 3 days. 2. For medical benefit: none.	1. For cash benefit: up to 4 days. 2. Medical benefit not compulsory.	1. For cash benefit: 3 days. 2. For medical benefit: none.	1. For cash benefit: 3 days. 2. For medical benefit: none.
Maximum Time Receivable	1. Cash benefit: 26-52 weeks for the same illness. 2. Medical benefit: (1) Until expiration of cash benefit. (2) Additional 52 weeks of convalescent care optional.	1. Cash benefit: 26 weeks in any 1 year. 2. Medical benefit: throughout life.	For the same illness, 20-52 weeks.	26-52 weeks in any 1 year, but not more than 13 weeks in a year for an illness for which benefit has been drawn more than 26 weeks in the previous year.	1. Cash benefit: for the same illness, 26 weeks in any 1 year but not more than 39 weeks in any 2 consecutive years. 2. Medical benefit: until expiration of cash benefit.	1. Cash benefit: 26 weeks in any consecutive 12 months. 2. Medical benefit: until expiration of cash benefit.
Cash Benefit	50-75 % of wages.	Minimum: Men: $2.40 weekly Women: $1.80 weekly.	60-75 % of wages.	50-90 % of wages.	60 % of wages.	66⅔ % of wages.
Medical Benefit	1. Medical and nursing assistance and treatment. 2. Medicines and therapeutic appliances. 3. Hospital care. 4. Medical treatment to dependents optional.	1. Medical treatment. 2. Medicines and limited list of therapeutic appliances. 3. Sanatorium benefit for all forms of tuberculosis. 4. Medical treatment to dependents optional. 5. Dental care optional.	1. Medical treatment. 2. Medicines and therapeutic appliances. 3. Hospital care. 4. Medical treatment to dependents optional.	Medical treatment and medicines provided by voluntary sick clubs. Must be open to any insured person. Cash benefit not paid until arrangements for medical treatment and medicines are made.	1. Medical and surgical treatment. 2. Therapeutic appliances; medicines optional. 3. Hospital and asylum care. 4. Medical and surgical treatment to dependents; medicines optional. 5. Dental care optional.	1. Medical, surgical and nursing assistance and treatment. 2. Medicines and therapeutic appliances, costing not more than $50 in any 1 year. 3. Hospital care. 4. Medical and surgical treatment and medicines to dependents.
Maternity Benefit	1. Insured women: (1) Cash benefit 2 weeks before and 6 weeks after delivery; *or* (2) Home nursing assistance or hospital care with half cash benefit. (3) Obstetrical, pregnancy and nursing benefit optional. 2. Wives of insured men: optional.	1. Insured women: (1) $7.20. (2) $14.40 if wives of insured men. 2. Wives of insured men: $7.20.	Insured women: (1) Obstetrical care. (2) Cash benefit for at least 4 weeks after delivery.	Insured women: (1) Cash benefit up to full wages during incapacity due to delivery. (2) Usual cash benefit during incapacity due to pregnancy.	Insured women: (1) Cash benefit for 6 weeks. (2) Medical treatment.	1. Insured women: (1) Cash benefit 2 weeks before and 6 weeks after delivery. (2) Medical, surgical, and obstetrical treatment and appliances. 2. Wives of insured men: medical, surgical, and obstetrical treatment and appliances.

Arrangements for Medical Service	1. Free choice between at least 2 physicians under written contracts with funds, if cost is not excessively increased. 2. Insured may be paid cost of medical service if reasonable contracts with sufficient physicians cannot be made.	1. Free choice among panel of physicians whose pay is arranged by Insurance Committees according to official regulations. 2. Other arrangements permitted if numbers on panel are insufficient.	Free choice among physicians under contract with funds who may be paid: (1) Fixed salaries; *or* (2) Capitation; *or* (3) By the visit.	Free choice between at least 2 physicians under contract with sick clubs.	Contracts with physicians by funds.	Funds may arrange for medical service by 1. Free choice among panel of physicians *or* 2. Reasonable free choice among salaried physicians; *or* 3. District medical officers; *or* 4. Combination of above methods.
Funeral Benefit	20-50 times average daily wage. Minimum of $12 may be fixed.	None.	At least 20 times average daily wage. Maximum, $20.	None.	25 times average daily wage. Maximum, $13.50.	Funeral expenses. Maximum $50.
Contributors	Percentage of wages from employer and employee.	Flat rate from employer, employee, and state. Contributions of employer and state proportionately increased for exceptionally low-paid workers.	Percentage of wages from employer and employee.	Percentage of wages from employer and employee.	Percentage of wages from employer, employee, commune, and state.	Percentage of wages from employer, employee, and state. Employer's contribution proportionately increased for exceptionally low-paid workers.
Insurance Carrier	1. District funds. 2. Other mutual societies not operated for profit (establishment funds, miners' funds, guild funds, etc.).	1. Cash benefit: (1) "Approved societies" (labor unions, establishment funds, friendly societies, etc.). Must be controlled by members and not operated for profit. (2) "Deposit contributors'" fund for those outside societies. 2. Medical and sanatorium benefit: representative Insurance Committee in each county.	1. District funds. 2. Other mutual societies not operated for profit may be recognized (establishment funds, registered aid funds, guild funds, etc.).	1. District funds. 2. Other mutual societies not operated for profit may be recognized (local funds, etc.).	1. District funds. 2. Other mutual societies not operated for profit may be recognized (shop clubs, communal sick funds, etc.).	1. District local or trade funds. 2. Other mutual societies not operated for profit may be recognized (labor unions, establishment funds, benevolent or fraternal societies, etc.).
Control of Carrier	Employers and employees; representation ⅔ and ⅓ respectively.	1. "Approved societies" by members. 2. "Deposit contributors'" fund by Insurance Commissioners. 3. Insurance Committees by insured, physicians, local administration and Insurance Commissioners.	Employers and employees; representation ⅔ and ⅓ respectively.	Employers and employees (representation equal), and impartial chairman appointed by Crown.	Employers, employees, and commune; representation 2/9, 5/9, and 2/9 respectively.	Employers and employees; representation equal.
Government Supervision	Local, state, superior and imperial insurance offices.	Insurance Commissioners.	Local, and provincial officials under Minister of Interior.	Insurance Committee.	State Insurance Institution.	State Social Insurance Commission.

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VOLUNTARY HEALTH INSURANCE IN NEW YORK CITY

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The investigation the results of which are here summarized was begun in June 1914 to meet the desire of the Committee on Social Insurance of the American Association for Labor Legislation for information concerning the number and kind of agencies furnishing health insurance within the city of New York.

In the search for information scores of visits were made to organizations as widely different in character as the United Hebrew Charities, the Association for Improving the Condition of the Poor, the American Federation of Labor, the Central Federated Union, the State Department of Labor, local traction companies, publishers of Italian, Hebrew, German, Greek, and Croatian newspapers, and executives of numerous educational, immigration, and philanthropic societies. Upon several occasions meetings of fraternal organizations were attended. Several funds were discovered only by walking through congested districts and copying from placards displayed in store windows the names and addresses of the societies thus publicly announcing their entertainments. In some instances where the usual sources failed to bring results the records of undertakers proved suggestive.

It was found that there exist in this great cosmopolitan city literally thousands of petty health insurance funds, most of them branches of larger organizations which belong to five principal types. For purposes of closer study, thirty-six of the largest of these organizations were selected, including representatives of each type, namely fourteen fraternal societies, eleven trade unions, seven mutual assessment societies, two private stock companies, and two establishment funds.

MEMBERSHIP

Many of these organizations maintain headquarters in New York and have branches throughout the country. Leaving outlying

lodges out of consideration, however, the number of persons in New York City carrying health insurance in the thirty-six funds especially studied may be estimated approximately as follows:

Fraternal societies	104,000
Trade unions	20,000
Mutual assessment societies	32,000
Stock companies	8,000
Establishment funds	6,000
Total	170,000

In the fraternals and the establishment funds all members are insured against sickness. The trade unions, mutual societies, and stock companies, however, have many members who do not carry health insurance, and in the above estimate only those actually carrying such insurance have been counted.

Health Requirements for Admission

The applicant's state of health, as far as this investigation could determine, is taken into account by every fraternal society, by most of the trade unions, by all mutual assessment societies and stock companies, and by the establishment funds visited.

All of the fraternal societies investigated admit only people in good health. Twelve of them require a medical examination of applicants; those ill at the time of application (whether the disease be chronic or acute) are not admitted.

Of the eleven trade unions visited, in two, members ill with chronic diseases are barred from the sick benefit fund; in four unions people in "good health" only are admitted to the union, and therefore, to the sick benefit; in two unions medical examination is required of participants in the sick benefit and ill people are not admitted to the fund; in two unions no special physical requirements exist; and in the last union no answer to this question was obtained.

Of the seven mutual societies two require medical examination of applicants; the five others require a detailed statement as to the applicant's health. Chronic diseases at the time of application debar from membership in these mutuals.

The same is true in one of the stock companies visited. An offi-

cial of the other stated that only sufferers from serious chronic diseases are barred. The establishment funds of a rapid transit company and of a well known show house require medical examination of all applicants for admission to the relief fund and only those in good health are accepted.

Discrimination Against Hazardous Occupations and Old Age

The particular hazard of the occupation is considered by only a part of the associations visited. Of the fourteen fraternal societies only one charges higher rates to workers in hazardous occupations; the others have no provision on the subject. The attitude of the trade unions is of course one of non-discrimination, since the members belong to one trade. More interesting is the attitude of mutual assessment societies and stock companies which, as usual in other branches of their business, give very careful attention to the occupation of the policy holder. One indemnity company, for instance, has a list of 3,600 occupations, which are graded according to hazard into nine classes, one of which is completely barred from insurance. In special health policies and in combination health and accident policies the premium charges for sickness indemnity increase with the hazard of the occupation. Mutuals and stock companies debar workers in extra-hazardous occupations, such as aviators, racers of all kinds, professional baseball players, and makers of explosives. Those at the other end of the line, people having no occupation, are also barred from insurance by one stock company and by some of the mutuals.

The usual maximum age limit for admission to fraternal societies ranges from forty-five to fifty years. There are some exceptions: one society does not admit men over thirty-five years, while another sets the maximum age of admission at sixty years. In some of the trade union funds the age limit is forty-five, in others fifty years; one does not admit members over forty years old. The mutuals and the stock companies usually admit elderly people, up to sixty years. One of the establishment funds admits no employee over forty-five years of age, but the other has no age restriction. In addition to the absolute exclusion of applicants beyond a certain age, many funds, as will later be shown, raise the rates of contribution for those in the older groups.

Admission of Women

Of the fourteen fraternal societies one is composed of women only, eight of men only; of the remaining five, three admit women on equal terms with men. One charges lower rates and pays smaller benefits to housewives, and one admits only the wives and unmarried daughters of the members and then only provided they are proposed by their relatives. In this society women pay smaller dues, but are permitted to carry life insurance only. Two of the larger Hebrew orders, numbering over 700 lodges in this city, do not admit women to membership with men, but one of these two has three separate lodges for women only. Among the trade unions, it is reported that women are always admitted to sick benefits whenever they are in the trade. Of the eleven union funds studied, three admit women—two on the same conditions as men, while one charges women lower rates and pays them smaller benefits. Six of the seven mutual societies admit women on equal conditions with men; one gives equal consideration if they are in occupations which are also pursued by men. One of the two stock companies visited does not insure women. The two establishment funds give women members equal privileges with men.

Premiums and Cash Benefits

Cash benefits during illness are given by every one of the health insurance funds which were studied. The premiums or dues payable in order to secure these cash benefits vary considerably in different organizations, and sometimes vary within the same organization according to the age or occupation of the applicant and the amount of benefit desired.

A majority of the fraternal societies require the payment of less than $1 a month; two charge $1 a month, and in two societies the dues exceed that amount. These payments, however, usually entitle the member to cash benefit only. The society charging the smallest dues, 20 to 55 cents a month, pays a sick benefit of $3 to $8 a week for a maximum of six weeks each year. As in all fraternal societies investigated, there is also a small death benefit. Of the two societies charging $1 a month, one furnishes a maximum of $100 a year sick benefit (and in addition $10 a week for hospital treatment as long as necessary). The sick benefit of the sec-

ond of these societies is customarily limited to $50 a year, although in some lodges it is higher. The dues of the fraternals sometimes depend on the member's age; one society not admitting persons over forty-five years old has three grades of rates, while another, with an age limit of fifty-seven, has four grades. Ten societies, however, have only one rate for all members.

In the trade unions it is sometimes hard to determine what part of the regular dues is devoted to sick benefit. In one union where the dues are 25 cents a week for men and 15 cents for women, 10 cents and 7 cents respectively go to the sick benefit fund. The benefit is $5 a week for five weeks a year to men and $3 to women. In another, a cigarmakers' local, people not entitled to sick benefit pay 15 cents a week less, so that apparently 15 cents a week is charged for this benefit, which amounts to $5 a week for thirteen weeks a year. Only one union has a charge expressly for sick benefit; it requires a contribution of 25 cents a month and pays $5 a week for ten weeks; certain tuberculous members receive a lump sum of $100 to $150 (for others there is medical treatment). The members of a German printers' local pay about $1 a week (90 cents and 1 per cent of wages), 30 cents of which go to the sick benefit fund; the regular benefit is $5 a week until $400 is paid, but some members pay lower dues and receive smaller benefits. In none of the unions visited is there a grading of rates according to age, one rate being used for all entitled to admission.

The mutual societies usually sell their insurance on a basis of monthly premiums. In five such cases the benefits vary from $2 to $20 a week, the premiums from 50 cents to $3 a month. These charges, however, include accident and life insurance. In some of the societies so-called "special policies" are sold at rates as high as $4.50 a month. Two of the seven mutuals visited sell policies on weekly payments only, their rates running from 5 cents to 40 cents a week. There is only one society which charges the former low rate. For this sum it pays a sick benefit of $2, but after the age of forty the rate is doubled for the same amount of benefit. The highest rate charged by this society for sick benefit alone is 20 cents a week, the corresponding benefit being $4 a week paid for eight weeks each year. In the other organizations also, the time for which a member is entitled to sick benefit is generally limited to a certain number of weeks a year, usually six to ten, though a few

pay for longer periods. The premium is increased 50 per cent and by some mutuals 100 per cent to applicants over fifty years old.

Of the two stock companies visited one usually conducts its business on an annual basis and charges for health insurance from $8 to $17 a year, according to the hazard of the occupation, for $5 a week sick benefit, payable for fifty-two weeks. There are two grades of rates according to age, people between fifty and sixty paying 50 per cent more than the regular charge, and eight grades according to the occupational hazard. The other stock company has in its industrial department different policies, on which the premium charges vary from $1 to $5 a month according to occupation. The benefit in case of sickness or accident runs from $12.50 to $60 a month, an additional benefit being paid in case of accidental death. Applicants between the ages of fifty and fifty-five are charged 50 per cent in addition to the regular premium while those between fifty-five and sixty are charged 100 per cent additional. The high cost of stock company health insurance is shown by the fact that according to their annual reports to the New York State Superintendent of Insurance one of these companies took in during 1914 in premiums for health insurance alone $73,216 and paid out in claims $30,714, while the second took in $400,448 and paid out $191,942.

One of the establishment funds examined charges 75 cents, $1.50, and $3 a month, and pays benefits of 50 cents, $1, and $2 a day for the first fifty-two weeks, after which the benefit is reduced one-half. In addition, there is a death benefit. The theater where the second establishment fund is located runs thirty-eight weeks a year, and the insurance is in force only during the season; dues are 10 cents a week during this period and an initiation fee of $3 is also charged. The benefit is $7 a week for six weeks, which by vote of the board of directors can be extended to twelve weeks.

The policy of providing only cash benefits has the serious defect that receipt of cash benefit alone may in some cases offer a stronger incentive to malingering than if the money were accompanied by medical care by the society doctor. It is frequently stated that private physicians, when asked for sickness certificates, are inclined to be lenient, whereas lodge doctors are more likely to be strict.

Medical Supervision

In all funds investigated a doctor's certificate is required with the application for sick benefit. The sort of physician supplying this certificate is considered important because, it is argued, a private physician may be in some cases more lenient than a lodge or society physician.

In almost all of the fraternal societies studied the certificate is furnished by the society doctor. The reverse is true of trade unions, only one of which has its own physician. The mutuals and one of the stock companies accept the certificate of any doctor. The second company and the two establishment funds accept only the certificates of their own doctors.

Another problem which all kinds of associations furnishing health insurance have to face is that of malingering. Besides the physician's certificate, the fraternal societies and trade unions have an additional safeguard in the form of the sick "visiting committee." They all, except one women's society, appear to have such committees, consisting of from one to seven persons usually selected in succession from the membership. It may be said, by the way, that friendly assistance, or the expression of condolence, is in many cases another object of the visiting committee. The mutuals have no sick committees; their safeguard against malingering is the doctor's certificate. None of the stock companies or establishment funds visited is provided with sick committees; judgments as to the member's state of illness are made by the company physician.

Financial Supervision

Methods of paying sick benefits and especially of verifying accounts are an important element in conducting health insurance. The fraternal societies and trade unions do their work in the same way. In the larger fraternal societies and trade unions the benefits are paid at the office. In the societies and unions that have no offices the benefits are either sent by mail, or taken to the sick member's home, or paid at the financial secretary's home. Receipts signed by the sick members are sent with the secretary's reports to the main office. Auditing committees are elected or appointed in each local fraternal society or union. The main organizations also

have auditing committees, and a few of the larger societies and unions employ expert accountants.

None of the trade union funds is under state supervision. Of the fourteen fraternal societies studied, only the six largest are so supervised. These are required to send annual reports to the state insurance department, and are subject to examination by the department every three years, but the actual period between examinations is usually somewhat longer.

In the seven mutual assessment societies and in one of the two stock companies visited, the benefits are paid usually at the office, but sometimes they are sent by mail. In the other stock company payments are made by authorized agents. Branches send reports to the home offices, where they are audited, and all mutuals and stock companies are under state supervision. In one establishment fund the benefits are paid by the treasurer of the company upon presentation of a certificate signed by the superintendent of the fund, whose accounts are audited annually. In the other establishment fund sick benefits are paid by the fund treasurer, accounts being audited quarterly. Establishment funds are outside of the state's control. In the larger of the two visited, the company has general charge of the benefit fund, while the smaller is entirely in the hands of the employees.

Medical Benefit

Practically the only voluntary health insurance agencies in New York City which furnish their members with medical care are the fraternal societies. Of the fourteen organizations of this class which were visited, only two fail in this respect. On the other hand, only one of the eleven trade unions and only one of the two establishment funds provide medical care, while this feature of health insurance is entirely neglected by all the mutuals and stock companies studied.

The medical care given by the fraternal orders visited, for which a charge in addition to the regular dues is usually made, consists of treatment by a physician selected by the organization, but no medicines or nursing services are included. In addition, seven of the societies make some effort toward meeting the need for hospital treatment. Thus one society, composed of German waiters, contributes $10 a year to a hospital, and is allowed the free use of a

bed "when one is vacant." A Serbian and a Greek federation each pay higher benefits when hospital care is needed. A large Jewish society provides hospital treatment only for tuberculous members. Those suffering from the disease are entitled to either six months at the organization's sanatorium at Liberty, N. Y., or $100 cash. Two other Jewish orders meet the problem much less efficiently. Both contribute considerable sums to hospitals, one having a special hospital fund out of which in the years 1911-1913 the sum of $13,273 was donated. According to the information received, there is no agreement with any special hospital, but "influence" is frequently used. When a member needs hospital treatment and is unable to meet the expense, it was reported, an officer of the lodge or some other member of higher social connections uses his "influence" with the authorities of one of the several hospitals to which the order contributes, and secures treatment for the needy member for as long a period as necessary. Not all lodges in these two orders furnish medical treatment. One secretary stated that the lodges composed of people of higher financial standing do not employ lodge doctors. The number of such lodges is very small, however.

The one union, of those investigated, which provides medical treatment is in exceptionally favorable circumstances for this purpose for it is under the jurisdiction of the Joint Board of Sanitary Control. It provides medical attendance for ill members, and tuberculous members who, in the doctor's opinion, require sanatorium treatment, are sent to Liberty, N. Y., where they may remain for twenty weeks in each year. The expense is paid by the union, and $1 a week in cash is given to each patient for incidental expenses. Visiting nurses are employed for the care of tuberculous members living in New York City.

The establishment fund which provides medical care is that connected with a playhouse. Here not only is a physician provided, who is paid by the employees, but he also dispenses medicine—the only case in which this is done among all the thirty-six societies visited. Nurses are always present in the theater for attendance on emergency cases.

Physician's Remuneration

The much-discussed question of the society or lodge physician's remuneration is answered almost uniformly by the fraternal so-

cieties visited. In eight societies, six of them national organizations with over 1,800 branches, the branches employ doctors at the rate of $1 a year per member, this fee usually being paid by the member in addition to his regular dues. If the member's family wishes to be included in the agreement, an additional $1 is charged; in some cases the extra charge is $2 and in one case only 50 cents. Two independent societies pay an annual salary of $175 and $225. This is for the treatment of members only; in one of these societies an additional charge is made of 50 cents a year for a family. One small German society pays its physician 50 cents a visit. The remaining two do not provide medical treatment for members.

Since the trade unions visited, with one exception, do not furnish medical benefit, they have no physicians in their employ. Although the mutual societies and the stock companies provide no medical care for their policy holders, they engage physicians as examiners. In the seven mutuals the remuneration of these examiners varies from $170 to $420 a year. In one of the two stock companies the physician is paid $2 for each examination; in the other he has also office duties to perform and is paid a salary.

Inefficiency of Medical Care

The prevailing absence of medical care among voluntary health insurance agencies obviously makes for highly unsatisfactory conditions of treatment for the insured. Members of trade unions, and those insured in the mutuals and in the stock companies, have to resort to private physicians. As trade union sick benefits are usually small, about $5 a week in most unions, and those of wage-earners insured in the mutual societies and stock companies are none too generous, it is doubtful whether they consult a doctor promptly and frequently enough. Furthermore, the quality of their medical service is questionable, as they are not always able to engage a physician who is efficient and of high standing in his profession.

The probable poor quality of medical service is a point which applies equally to the small fraternal societies, including lodges of big orders. The small remuneration paid usually fails to attract as "lodge doctors" any but young, inexperienced beginners, willing to work for the barest livelihood in order to "make a start."

As a result, hospitals and dispensaries, especially the latter, are heavily patronized by wage-earners, and the services of these institutions, because they command better instruments and methods, are often preferable to the treatment given by individual doctors. Unfortunately, complaints are frequently heard of carelessness and incivility on the part of the staff towards the people who are compelled to use the dispensaries and hospitals. It is also very frequently stated in the press and verbally, even by members of the medical profession, that the demand on these two classes of institutions is far in excess of their equipment, so that patients do not receive the full amount of necessary attention.

Some Defects in the Policies of Mutual Societies and Stock Companies

Both mutuals and stock companies—especially the latter, which are in business for profit—occasionally put into their policies a number of clauses which diminish the apparent value of the insurance agreement. For instance, a statement in prominent type as to the weekly benefit paid by the company is usually followed, though not immediately, by an enumeration, in small type, of conditions under which the insured is to receive a smaller benefit. Thus no benefit is paid by some companies unless the doctor visits the insured twice a week. Other companies reduce the benefit if the insured was injured during an act which does not pertain to his regular occupation. Some common diseases are excluded by certain companies. One of the companies visited, for example, states: "No benefits shall be allowed for any disability caused by rheumatism, sciatica, neuralgia, lumbago, strained or sprained back, venereal disease, varicose veins, hemorrhoids, nervous prostration, and not to exceed one week of la grippe, neuritis, gastritis and bronchitis." By other organizations disability and death resulting from such chronic diseases as heart disease, tuberculosis, cancer, apoplexy, Bright's disease, paralysis, and epileptic fits are during the first two to four years of insurance compensated only partially. The clauses are in some cases ambiguous and settlements frequently bring disappointment to the policy-holders.

Health Education

The important matter of instructing people in ways of guarding their health is given no consideration in a large majority of the

organizations investigated. The fraternal societies do little or nothing. One of them occasionally publishes articles and arranges lectures on the prevention of tuberculosis. Another prints in its monthly paper at irregular intervals articles on health.

Of the eleven trade unions, only two undertake preventive work. A large printers' union has in every shop or "chapel" a sanitary subcommittee, consisting of one member, the "time chairman" elected by the workers. He usually supervises sanitary conditions in the shop, but as there are no particular rules or standards each chairman in turn acts according to his individual judgment. When something seems to him insanitary he reports it to the sanitary committee of the local, consisting of three people appointed for a year by the president. This committee from time to time takes up questions of sanitation with the state department of labor. Much more efficient preventive work is done by the Joint Board of Sanitary Control in the garment trades, but of the unions visited only one is under the jurisdiction of this board. In two cases it was stated that very rarely, once in several years, representatives of the board of health lectured before the union.

The mutuals, the stock companies, and the establishment funds visited report no preventive work.

Conclusions

To summarize the main findings, it can be stated that a considerable number of wage-earners in this city are carrying health insurance of the unsatisfactory kinds described. Many, however, are still not provided for, either because they are unable to bear the cost or because they are disqualified. Discrimination is exercised against three probably numerous groups of people, namely, people not in good health ("poor risks," in insurance terminology), those engaged in hazardous occupations, and persons in middle life. Women, also, are barred by many fraternals, by some of the mutual societies and stock companies.

Another weak point of the present inadequate system of health insurance is the lack of state control. A large number of fraternal societies and all trade unions and establishment funds are outside of state supervision so that no protection is furnished to the financial interests of the members.

The benefits paid are small and of short duration. Whether in the form of cash or a combination of cash and medical attendance, they do not result in as much advantage to the beneficiary as they would if efficient medical care were a part of the system. Medical care is not common, and when it is provided it is likely to be very inadequate.

As to the cost of insurance, it is generally agreed that this cost is high in the stock and even in the mutuals. It is lower in the fraternals and mutuals, but these agencies, except, perhaps, their largest representatives, are lacking in security.

Last, but not least, the very important problem of disease prevention seems to be wholly ignored by the existing agencies for health insurance. Apparently no method has been devised by them, or even considered, for bringing financial pressure to bear upon those who can be most effective in the necessary work of health conservation.

Throughout the study, the main impression gathered was the need of an adequate universal system of health insurance, at minimum cost, which would be financially sound and which would bring employers and employees together for actual local administration under state supervision and for preventive work.

BRIEF FOR HEALTH INSURANCE

The American movement for health insurance rests upon the recognition of the following six points:

I. High sickness and death rates are prevalent among American wage-earners.

II. More extended provision for medical care among wage-earners is necessary.

III. More effective methods are needed for meeting the wage loss due to illness.

IV. Additional efforts to prevent sickness are necessary.

V. Existing agencies cannot meet these needs.

VI. Compulsory contributory health insurance providing medical and cash benefits is an appropriate method of securing the results desired.

I. HIGH SICKNESS AND DEATH RATES ARE PREVALENT AMONG AMERICAN WAGE-EARNERS.

A nation can be no stronger than its industrial workers. The amount of ill health at present existing among the wage-earners of America calls for vigorous social action for its cure and prevention.

1. The Amount of Disability Due to Sickness among Wage-Earners Is High.

In the United States, as in other countries before comprehensive systems of health insurance were instituted, complete morbidity statistics are lacking. Every investigation which has been made, however, shows a large amount of disability due to sickness among working people.

A community sickness survey by the Metropolitan Life Insurance

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"The complete morbidity data which will be collected through the operation of such a system as well as the money value it places upon good health, will be a powerful factor in the prevention of sickness among the industrial population."—Weekly Bulletin of the Department of Health, New York City, January 29, 1916.

Company, for instance, resulted in the estimate that in Rochester, N. Y., of each 1,000 males 15 years or over, 23.3 are ill at any one time, and that of each 1,000 women 15 years or over, 25.7 are so ill at any one time that they are unable to work. This means for men an average of 8.5 days of disability a year and for women 9.4 days. For the entire city of Rochester this means that 2,147 men over 15 are constantly sick, which, assuming 300 working days a year, makes a total of 644,000 days of disability. Of the total 34,490 persons of all ages covered among the working class, 2 per cent had been ill more than one week.[1] The results of a smaller survey in Trenton, N. J., correspond closely with those in Rochester.[2] A recent study in Indiana showed that 17.9 per cent of unemployment among women in stores in that state was due to illness.[3] In 1901 a federal investigation of 25,440 workmen's families showed that 11.2 per cent of heads of families were idle during the year solely on account of sickness and that the average period of such unemployment was 7.71 weeks, or an average for all the heads of families, sick and well, of 11.2 per cent $\times$ 7.71 $\times$ 7, or six days. An additional 3.7 per cent of heads of families idle for combinations of reasons in which sickness was one element would increase the average.[4]

For the country as a whole an estimate based upon German experience indicates that among the 33,500,000 occupied men and women there occur annually 13,400,000 cases of illness, causing 284,750,000 days of disability, or an average of 8.5 days per person.[5]

Probably the most extensive actual study in this field was undertaken for the recent federal Commission on Industrial Relations.

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[1] Lee K. Frankel, "Community Sickness Study," United States *Public Health Reports,* February 25, 1916, pp. 431, 433, 435.

[2] *Ibid.*, p. 437.

[3] *Final Report of the Commission on Industrial Relations,* 1915, p. 202.

[4] *Eighteenth Annual Report of the U. S. Commissioner of Labor,* "Cost of Living and Retail Prices of Food," 1903, p. 45.

[5] American Association for Labor Legislation, "Memorial on Occupational Diseases," *American Labor Legislation Review,* January 1911, p. 127.

"I believe health insurance which protects workingmen during a period of sickness is just as important as compensation insurance to protect workingmen during injuries received while following their occupation. —Van Bittner, President, District No. 5, United Mine Workers of America.

The investigation covered nearly 1,000,000 workers in representative establishments and occupations, and as a result it was tentatively stated that each of this country's 30,000,000 workers loses annually an average of about nine days on account of illness alone. "Much attention is now given to accident prevention," declares the commission, "yet accidents cause only one-seventh as much destitution as does sickness."[7]

2. The Industrial Population Has a High Tuberculosis Death Rate.

Tuberculosis, which is peculiarly a disease of overwork, malnutrition, and insanitary surroundings, is a prevalent cause of death among the industrial population.

Hayhurst has shown that of 140 specified occupations listed in the United States mortality statistics for 1909, tuberculosis, "the 'captain of death' among occupied persons," was the chief cause of death in ninety-six.[8]

A federal investigation in Fall River in 1907 showed that among cotton mill operatives ten years of age and over 32.8 per cent of the 287 male deaths and 37.5 per cent of the 299 female deaths studied were due to this disease. Among persons ten years and over who were not cotton mill operatives, 13.9 per cent of the 1,097 male deaths and 8.5 per cent of the 1,271 female deaths studied were due to the same cause.[9]

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[6] B. S. Warren and Edgar Sydenstricker, "Health Insurance: Its Relation to the Public Health," United States *Public Health Bulletin* No. 76, March 1916, p. 6.

[7] *Final Report of the Commission on Industrial Relations,* 1915, p. 202.

[8] Emery R. Hayhurst, "The Appalling Mortality among Occupied Persons Due to Preventable Causes," Ohio State Board of Health *Monthly Bulletin,* August, 1913.

[9] Arthur R. Perry, "Causes of Death among Woman and Child Cotton-Mill Operatives," *Report on the Condition of Woman and Child Wage-Earners in the United States,* Senate Document 645, 61st Congress, 2nd Session, Vol. XIV, p. 71.

"In my opinion, insurance against occupational diseases and sickness or, in other words, health insurance, is of far greater importance to society than accident insurance."—James H. Maurer, President, Pennsylvania Federation of Labor.

In dusty trades, generally, the tuberculosis death rate is particularly high, as the following table shows:[10]

MORTALITY FROM CONSUMPTION, 1897-1906, IN OCCUPATIONS EXPOSED TO DUST, COMPARED WITH THAT OF ALL MALES AGED FIFTEEN OR OVER IN THE UNITED STATES REGISTRATION AREA, 1900-1906

	Percentage of Deaths Due to Consumption
Males, registration area, 1900-1906	14.8
Occupations exposed to vegetable fiber dust	24.8
Occupations exposed to mineral dust	28.6
Occupations exposed to animal and mixed fiber dust	32.1
Occupations exposed to metallic dust	36.9

In 1914 in Massachusetts, where the Metropolitan Life Insurance Company insured one out of every six persons in the state, tuberculosis caused 13.4 per cent of the total 7,273 deaths among this company's industrial policy holders, whereas among the general population over one year of age tuberculosis accounted for 9.6 per cent of the total 43,315 deaths of 1913.[11] "This," says Louis I. Dublin, statistician for the company, "is an important difference, and may be directly charged to the greater life strain to which the industrial classes of the community are subjected. Tuberculosis mortality is especially significant because it affects the main working period of life, the average age of those dying from tuberculosis being thirty-seven years." The relative frequency of death from pulmonary tuberculosis in various trades and professions is graphically brought out by the chart on the opposite page.

3. Death from Degenerative Disease of Middle Life Is Prevalent among Wage-Earners.

Not only does tuberculosis visit the homes of wage-earners with excessive frequency, but deaths from degenerative diseases of middle

[10] Frederick L. Hoffman, "Mortality from Consumption in Dusty Trades," United States Bureau of Labor *Bulletin No. 79*, pp. 681, 726, 783, 829.

[11] Louis I. Dublin, "Mortality of the Industrial Population of Massachusetts," Massachusetts State Department of Health *Public Health Bulletin*, Vol. 2, No. 10, November 1915, p. 274.

"There is to-day being launched a greater movement than that against tuberculosis, a movement against all unnecessary diseases through an American system of health insurance..... Even on the score of money economy, it will pay employers, employees, and society to institute a system of safeguarding the health of the people."—Irving Fisher, Professor of Political Economy, Yale University, 1916.

PULMONARY TUBERCULOSIS.

Number of Deaths per 100,000 of Population in the Registration Area among Males 10 Years of Age and Upward in Specified Occupations: 1900.

MARBLE AND STONE CUTTERS 541
CIGARMAKERS AND TOBACCO WORKERS 477
COMPOSITORS, PRINTERS, AND PRESSMEN 453
SERVANTS 436
BOOK KEEPERS, CLERKS, AND COPYISTS 430
LABORERS (NOT AGRICULTURAL) 415
TINNERS AND TINWARE MAKERS 398
CABINETMAKERS AND UPHOLSTERERS 371
MUSICIANS AND TEACHERS OF MUSIC 365
BARBERS AND HAIRDRESSERS 359
SAILORS, PILOTS, FISHERMEN, AND OYSTERMEN 350
PAINTERS, GLAZIERS, AND VARNISHERS 342
LEATHER MAKERS 335
APOTHECARIES, PHARMACISTS, ETC 333
COOPERS 319
PLUMBERS AND GAS AND STEAM FITTERS 311
MASONS (BRICK AND STONE) 306
BUTCHERS 300
SALOON AND RESTAURANT KEEPERS 294
LIVERY STABLE KEEPERS AND HOSTLERS 294
DRAYMEN, HACKMEN, TEAMSTERS, ETC. 288
BOATMEN AND CANALMEN 286
BREWERS, DISTILLERS, AND RECTIFIERS 268
JANITORS AND SEXTONS 261
HUCKSTERS AND PEDDLERS 257
BAKERS AND CONFECTIONERS 251
IRON AND STEEL WORKERS 251
CARPENTERS AND JOINERS 250
ENGINEERS AND FIREMEN 236
LEATHER WORKERS 231
TAILORS 230
BLACKSMITHS 227
HOTEL AND BOARDING HOUSE KEEPERS 218
MILL AND FACTORY OPERATIVES (TEXTILES) 213
MILLERS (FLOUR AND GRIST) 210
MACHINISTS 208
ARCHITECTS, ARTISTS, TEACHERS OF ART, ETC. 196
JOURNALISTS 189
GARDENERS, FLORISTS, AND NURSERYMEN 187
PHYSICIANS AND SURGEONS 169
MERCHANTS AND DEALERS 164
SCHOOL TEACHERS 145
LAWYERS 144
POLICEMEN, WATCHMEN, AND DETECTIVES 140
BOOT AND SHOE MAKERS 137
COLLECTORS, AUCTIONEERS, AND AGENTS 136
STEAM RAILROAD EMPLOYEES 135
CLERGYMEN 131
MINERS AND QUARRYMEN 130
FARMERS, PLANTERS, AND FARM LABORERS 124
LUMBERMEN AND RAFTSMEN 121
BANKERS, BROKERS, AND OFFICIALS OF COMPANIES 112

United States Census Bureau: Tuberculosis in the United States, 1908.

life are also very prevalent. Public health authorities are now taking pains to point out that among adults in this country deaths from degenerative diseases—*i.e.*, diseases of the heart, blood vessels, and kidneys—have practically doubled during the last thirty years,[12] and two recent writers[13] have even called these diseases "menaces to national vitality."

On this point the following industrial experience of the Metropolitan Life Insurance Company is of special value:

COMPARISON OF MORTALITY RATES—WHITE MALES AND FEMALES—BY PRINCIPAL CAUSES OF DEATH

(*Metropolitan Industrial Experience, 1911, Paid-up Policies Excluded, Ages 15 and Over*)

Cause of Death	*Males*	*Females*
	Per 100,000 at Risk	
Tuberculosis (all forms)	353.46	219.82
Organic diseases of the heart	198.85	193.45
Diseases of the arteries	32.74	22.31
Pneumonia (all forms)	143.04	103.33
Cirrhosis of liver	36.47	17.54
Bright's disease	154.92	125.72

"It may be assumed," declares Dr. Lee K. Frankel on the basis of these figures, "that the males and females referred to in this table belong to the same social stratum and that their home environment is the same. The excess in male deaths must, therefore, be attributed to the occupational hazards to which the men are exposed. The females, in the main, are wives of working men and lead more sheltered lives."[14]

That degenerative diseases are, in part, a result of the industrial strain imposed upon men is further indicated by life insurance experience in Massachusetts. In that state, notwithstanding the exclu-

[12] Eugene Lyman Fisk, "Diseases of Adult Life and Middle Age," New York State Department of Health, *Health News*, May, 1915.

[13] Josephine Goldmark and Felix Frankfurter, *Brief for Defendant in Error,* Oregon men's ten-hour law case, U. S. Supreme Court, October term, 1915.

[14] Lee K. Frankel, "Occupational Hygiene," paper read before the Detroit Conference, Niagara Falls, September 1913, reprint, p. 3.

"The provision of medical care alone promises much for the prevention of sickness through detection of incipient diseases."—New York Sun, January 29, 1916.

sion of the poorer risks through medical inspection, the death rates from organic diseases of the heart, nephritis and Bright's disease among Metropolitan industrial policy holders are higher than those for the general population. While the difference between the death rates of these selected workers and of the general population is slight for the state as a whole, for individual industrial cities, such as Worcester, it is very marked.[15]

The study of degenerative diseases and the medical examinations made by the Life Extension Institute have led Dr. Eugene Lyman Fisk, its director of hygiene, to believe that although the statement does not apply to the higher grade mechanics, "there is a higher mortality rate from degenerative affections among the mass of industrial workers."

4. An Excessive Infant Mortality Rate Is Found among the Industrial Population.

Recent studies in this country show the truth for America of what has repeatedly been proven abroad, that there is an excessively high infant death rate among the wage-earning section of the population. In Johnstown, Pa., for example, it was found that in the ward where lived the poorest paid part of the community, those doing unskilled work in the mines and steel mills, the infant mortality rate was twice that of the city as a whole, and five times that of the most favorable sections.[16] Throughout the city the mortality rate for all live babies under one year born in wedlock was 130.7 per 1,000. In families where the father earned $1,200 or more a year, or had "ample" income, the death rate was 84 per 1,000; when the father earned less than $521 a year or less than $10 a week, the death rate rose to 255.7 per 1,000. A similar study in Montclair, N. J., showed precisely the

[15] Louis I. Dublin, "Mortality of the Industrial Population of Massachusetts," Massachusetts State Department of Health, *Public Health Bulletin*, November 1915, p. 274.

[16] Emma Duke, "Infant Mortality in Johnstown, Pa.," United States Department of Labor, Children's Bureau, *Bureau Publication No. 9*, 1915, p. 46.

"There is a vicious circle about disease and poverty. Poverty is well recognized as the chief cause of disease, and, in turn, disease very often plunges families into the abyss of poverty. Under our present economic and social conditions there is hardly a better remedy for the two scourges of our industrial population than social insurance."—Weekly Bulletin, New York City Department of Health, January 22, 1916.

same tendency—a heightened infant mortality rate with a decrease in the family income.[17]

If it be true that "a high infant mortality implies a high prevalence of the conditions which determine national inferiority,"[18] the infant death rate shown among American workers is indicative of conditions which stand sorely in need of correction.

5. The General Death Rate among Wage-Earners is High.

The experience of companies which do both an industrial life insurance business for small weekly payments among the lower paid workers and an ordinary business among other classes also shows a high mortality among the working population. The late John F. Dryden, president of the Prudential Insurance Company of America, testified before the Armstrong investigating committee in 1905 that the mortality among the class from which his company drew its industrial policy holders was higher than among "ordinary" policy holders,[19] due to the poorer clothing, less adequate food, and the absence of other "comforts and necessities of life" enjoyed by other portions of the population. Similar testimony was given by John K. Hegeman, president of the Metropolitan.[20] As far as can be determined, this situation has not changed since 1905.

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[17] "Infant Mortality, Montclair, N. J.," United States Department of Labor, Children's Bureau, *Bureau Publication No. 11,* 1915.

[18] *Journal of Royal Sanitary Institute,* London, 1915.

[19] State of New York, *Testimony Taken by the Legislative Insurance Investigating Committee,* 1905, Vol. 4, p. 3704.

[20] *Ibid.,* Vol. 2, pp. 1922, 1923.

"Sickness insurance managed by the state is becoming a real possibility in Ohio."—Ohio State Medical Journal, June, 1916.

II. BETTER PROVISION FOR MEDICAL CARE AMONG WAGE-EARNERS IS NECESSARY.

Most wage-earners and their families do not have proper medical attention, as judged by modern standards, and very many of them entirely lack the advice of physicians and the most elementary nursing—even in maternity cases. Many of them are unable to pay the fees for private physicians' care; free hospital wards, dispensaries, and nursing service fail to meet the whole problem; and medical equipment is too scarce and too scattered for the universal provision of modern up-to-date treatment.

1. Wage-Earners Are Unable to Meet the Expense of Proper Medical Care.

In the *Memorial on Occupational Diseases* it was estimated that at the rate of $1 for each day of disability the annual expense of medical care among America's gainfully occupied men and women was $284,750,000.[1] More recently the federal Commission on Industrial Relations calculated that at the rate of only $6 for each person the cost of treatment for the country's wage-earners amounted "at the very least" to $180,000,000 yearly.[2] On all sides it is rapidly becoming realized that wage-earners cannot meet these huge expenditures as at present distributed. During 1915 an analysis was made of the financial condition of 75,000 applicants to the Boston (Mass.) Dispensary. Of all the families with which the dispensary was in touch, 37 per cent lived on an annual income, including earnings of children, of $600 or less; 49 per cent on $700 or less; 70 per cent on $800 or less; and 83 per cent on $1,000 or less. If the income of the chief wage-earner alone be considered, but 3.5 per cent had more

[1] American Association for Labor Legislation, "Memorial on Occupational Diseases," *American Labor Legislation Review*, January 1911, p. 127.

[2] *Final Report of the Commission on Industrial Relations*, 1915, p. 202.

"A health insurance law, enabling persons with moderate incomes to command the paid services of the physicians is per se a great advance in health work."—E. H. Lewinski-Corwin, Executive Secretary, Public Health Committee, New York Academy of Medicine.

than $1,000 a year. Nevertheless, the report states, "It is a general opinion among students of wage-earners' budgets that even small families in this vicinity living on $1,000 or less should not be expected to purchase more medical service than that necessary to childbirth and acute illness in the home."[3]

Among 166 male heads of families studied by this dispensary, 264 cases of illness were found during the year. Although 73 of these cases were sufficient not merely to incapacitate the patient for work but to confine him to bed, 11 per cent of the bed cases were without medical aid of any kind. Among 137 cases not requiring confinement to bed, 53 per cent did not secure a physician.[4] In a special study, eligibility for treatment in the dispensary was questioned in 163 cases out of 1,414 (11.6 per cent) on the ground of ability to pay; after a study of the character of treatment required, only 1.12 per cent of the total were considered able to pay the minimum rates for private care. The dispensary estimates that among the population of a city like Boston probably one-fourth of the population is in a similar position. In the population as a whole it estimates that a majority of the self-supporting wage-earners are able to pay for cases of "ordinary illness" but are utterly unable to pay for medical assistance during prolonged illnesses or for the expensive services of specialists.[5]

It is not alone in Boston or in other large cities that wage-earners do not receive adequate medical care. For instance, the survey of sickness in five representative districts in Dutchess County, N. Y., made by the State Charities Aid Association, showed that in 1,600 cases of illness 882 of the patients, or more than half, though able to pay for "ordinary services" were unable to stand a prolonged drain upon family resources, while 212, or 13.2 per cent, were unable to pay for any service at all.[6] In all, 24 per cent of these patients re-

[3] Boston Dispensary, *Report for 1915*, p. 44.

[4] *Ibid.*, p. 17.

[5] *Ibid.*, pp. 17, 46.

[6] State Charities Aid Association, *Sickness in Dutchess County, New York*, 1915, p. 92.

"The failure of many persons in this country at present to receive medical care constitutes the best argument for a change to the more effectual provision for medical attention offered by health insurance."—Journal American Medical Association, October 30, 1915.

ceived no medical care, and "many startling instances of unnecessary and indefensible suffering and misery were found."[7]

An even more startling lack of medical care was disclosed by the Rochester survey already mentioned. Thirty-nine per cent of the cases of sickness found did not have a physician in attendance. Of the total 661 persons whose illness was serious enough to prevent them from working, but 63.8 per cent had medical attention, while of 137 who were ill, but able to work, only 45.3 per cent were under a doctor's supervision.[8]

In the matter of dental service, also, necessary treatment is often foregone because of lack of funds. The teeth of a factory girl described by the New York Factory Investigating Commission needed the dentist's care badly. "But," she remarked, "I haven't the money to pay for having them fixed so I just let them go on hurting me."[9]

In all branches of medical work large numbers of wage-earners have only inadequate attention, or none at all, because of their inability to meet the cost upon the present basis of payment. Moreover, as will later be brought out, it is not just that the entire burden fall upon the worker.

2. Free Hospital Wards and Dispensaries Are Not Sufficient and Are Objected to by Many Wage Workers as Charity.

In recognition of the inability of masses of wage-earners to purchase at regular rates the medical attention they need, free and partly free hospital wards and dispensaries have sprung up in large numbers in all the more important centers. Within the last fifteen years the number of dispensaries in this country has increased seven-fold.

In New York City alone forty-six hospitals associated with the United Hospital Fund, formerly the Hospital Saturday and Sunday Association, cared during the year 1913-1914 for 69,474 patients

[7] *Ibid.*, p. 4.

[8] Lee K. Frankel, "Community Sickness Survey," United States *Public Health Reports,* February, 1916, p. 434.

[9] Esther Packard, "Living on Six Dollars a Week," *Fourth Report of the* (New York) *Factory Investigating Commission,* 1915, Vol. IV, p. 1686.

"Health insurance is essential to the toiler who earns enough to support his family and no more. When sickness comes he and his are subjects of charity. This is fair neither to the individual nor to the race."—Brooklyn (N. Y.) Times, May 13, 1916.

(57 per cent of their total) who paid nothing for their treatment. In addition there were 25,168 part paying patients (21 per cent of the total). Of the total 2,183,538 days of treatment, 60 per cent were wholly free, and 13 per cent were paid for by the city, making a total of 1,581,673 days of treatment, or 73 per cent of the total, for which the patient paid nothing.[10] The dispensaries of the hospitals of this association during 1913-1914 were attended by 603,871 patients, who paid a total of 1,843,011 visits.[11]

Throughout New York state as a whole the hospital accommodations under supervision of the State Board of Charities include 185 private hospitals, which during the year ending September 30, 1915, cared for a total of 302,529 patients. Of this number 140,075, or 46 per cent, were cared for as public charges or as free patients.[12] During the preceding year city, county, and state hospitals provided 119,581 free patients with 2,920,723 days of treatment,[13] while in addition county, city, and town alms houses cared for about 8,100 sick or infirm persons.[14] The 187 dispensaries under supervision of the board recorded in 1915 a total of 4,864,699 treatments, of which 4,651,117 were in New York City.[15] There were also 173,967 visits to homes by doctors and nurses.

Provision of free dispensary service is, of course, not limited to New York state. Of 211 cities in all parts of the country, sixty-six reported a free dispensary service, administered by the health department in twenty-two cases, by the charity department in eighteen, by the city hospital in ten, and by private organizations or other means

[10] Hospital Saturday and Sunday Association, New York City, *Report for 1915*, p. 26.

[11] *Ibid.*, p. 30.

[12] *Forty-ninth Annual Report of the New York State Board of Charities*, for the year 1915, p. 250.

[13] *Ibid.*, pp. 784, 790, 837, 840.

[14] *Ibid.*, pp. 87, 120.

[15] *Ibid.*, p. 210.

"There is a great need for a law of this kind. The average wage-earner cannot afford to carry health insurance, and when laid up, is cast on the state institutions for treatment. Ultimately the public pay the bill."—The Insurance Advocate, Feburary, 1916.

in the remaining cities. It was, however, the larger cities in which this service was most frequently found.[16]

Yet even these extensive provisions fall far short of the need. In the Dutchess County study it was found that hospital treatment was secured by only 10 per cent of the total 1,600 patients, whereas investigation showed that 28 per cent of the cases could have been adequately cared for only in a hospital. In other words, three times as many patients needed hospital care as actually received it.[17] According to the United Hospital Fund, in New York,

> Beyond question there are large numbers who need hospital treatment but fail to apply because they do not want to become objects of charity. At present only one in ten persons seriously ill or injured in this city now gets treated in any hospital. For lack of proper treatment thousands lose their health and efficiency and become a burden to their friends and the community.

Nor do the dispensaries in New York City with their four and a half million treatments in one year reach all who need medical attention. A careful investigation in 1910[18] showed that notwithstanding that many were unable to employ a private doctor, and that others were unwilling to apply to a hospital (only 9.8 per cent of those ill had hospital treatment), only 32.3 per cent of the 600 sick persons visited on the lower east side had attended a dispensary. Even this attendance was frequently inadequate since 29 per cent of those attending went but once, on account of the crowded conditions, long delays, and often superficial examination. In the middle west side district neglect of the sick was even more common than on the east side. Here but 21 per cent of those ill during the year had ever visited a dispensary, and of these 15 per cent went but once, largely because they considered the treatment inefficient.

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[16] Franz Schneider, Jr., *Survey of the Activities of Municipal Health Departments in the United States,* Russell Sage Foundation, Department of Surveys and Exhibits, 1916, p. 14.

[17] State Charities Aid Association, *Sickness in Dutchess County, New York,* 1915, pp. 3, 93.

[18] *Report of the Committee of Inquiry into the Departments of Health, Charities, and Bellevue and Allied Hospitals to the Board of Estimate and Apportionment,* New York City, 1913, pp. 532-534.

"As a public health measure, this is one of the most important bills which has come before the legislature for many years."—Weekly Bulletin of the Department of Health, New York City, January 29, 1916.

The failure of both voluntary and state charitable efforts to meet the situation is particularly well illustrated by the extension of care for tuberculosis. As the result of widespread popular agitation against this preventable disease in the United States, there has been a phenomenally rapid increase in equipment for its care during the last ten years. Instead of a mere handful of hospitals and dispensaries there are to-day 575 hospitals, sanatoria and day-camps with a total of about 35,000 beds, and 450 special dispensaries.[19] It is doubtful if the increase in facilities for treating any other disease has been as rapid. Nevertheless accommodations are still far from adequate, for applying to the whole country the death-rate in the registration area, which, in view of the greater attention to health matters in that part of the country, is probably relatively low, it is calculated that there were at least 145,000 deaths from tuberculosis in the United States in 1914. In spite of active organization against the disease in the state we read in the *Illinois Health News,* "In the warfare against tuberculosis, Illinois has done comparatively little in the past."[20] In New York City, 37,000 cases of tuberculosis are known to the department of health. Of this number 3,200 are registered under the care of private physicians and 6,000 under the care of city institutions, while it is estimated that 15,000 are treated at clinics. This leaves 12,800 cases, or approximately a third of those known to the board of health, which are not known to be under treatment of any sort.[21] In addition the board estimates that there are 13,000 cases of which it has no record, among which it would seem that a far smaller proportion is likely to be under treatment.

Despite their rapid and widespread development, it is clear that hospitals and dispensaries are unable to cope with the mass of illness

[19] "The Campaign against Tuberculosis," *Journal American Medical Association,* January 8, 1916, p. 118.

[20] "Health Work in Illinois for 1915," *Illinois Health News,* January, 1916, p. 11.

[21] *Journal American Medical Association,* December 18, 1915, p. 2176.

"Workmen's compensation is just the beginning of a great movement that will result in the establishment here of sickness insurance of the kind already in existence abroad."—S. S. Goldwater, M. D., Superintendent Mt. Sinai Hospital, New York City.

among men and women. Moreover, these services should not be rendered through a system which tends to pauperizing.

3. Obstetrical and Other Home Nursing Care Is Insufficient.

A more recent extension of medical care to those who are unable to provide it for themselves is found in the visiting nurses' service maintained by some boards of health or other organizations. Board of health nursing service is most often concerned with tuberculosis and with infant welfare work. Thus in fifty cities out of 209 in all parts of the country board of health activities included the visit of a nurse or of a medical inspector in all reported cases of tuberculosis. In eighty-nine cities the board either employed visiting nurses or maintained infant welfare stations.[22]

The nursing of the sick undertaken by volunteer nursing organizations is more widespread. A report, now somewhat out of date, states that in New York there were in 1909, 108 organizations with 458 nurses, while throughout the country there were 566 organizations with a total staff of 1,413 nurses.[23] The movement has grown rapidly as shown by recent information which indicates that in the early months of 1916 in New York state alone there were 358 such associations with a staff of 1,365 nurses, while throughout the country there are approximately 2,000 organizations with a staff of more than 5,000 nurses. In New York City alone, the district nursing service of the Henry Street Settlement has a staff of nearly 100 nurses who in 1915 made a quarter of a million visits to 26,575 patients.[24] Nursing care is now also provided by the Metropolitan Life Insurance Company, for its own policy holders, in 1,700 cities and towns in twenty-eight states, the District of Col-

[22] Franz Schneider, Jr., *Survey of the Activities of Municipal Health Departments in the United States*, pp. 8, 16.

[23] Yssabelle Waters, *Visiting Nursing in the United States*, 1909, pp. 14, 365.

[24] *Visiting Nursing Service Administered by the Henry Street Settlement, New York City*, p. 5.

"Balancing all objections against sickness insurance over against the good that would come from a thorough system, I find the scale coming down heavily on the side of the latter."—E. P. Lyon, M.D., Dean of the Medical School, University of Minnesota.

umbia, and in the greater part of Canada through 750 nursing centers.[25]

Yet in the Dutchess County survey it was found that of the 1,441 patients ill in their homes 45 per cent received inadequate attention. Aside from physicians' visits, features frequently lacking were suitable nursing care and domestic help during illness.[26] In the words of the report, "There were in most cases no facilities for service to be had, and in other cases there was a lack of proper knowledge as to what service to seek for and how to seek it."[27]

The lack of skilled obstetrical aid for wives of wage-earners is an equally serious omission in medical care. Causes connected with childbirth are responsible for 10,000 deaths of mothers in the registration area annually, many of which could be prevented by proper obstetrical attention. Unfortunately this is not alone a city problem, as is sometimes thought. In Dutchess County records were secured of 126 confinements, of which 10 per cent occurred in hospitals and the remainder at home. Of the 113 at home, 15 per cent were without any medical attendance (eleven being attended by midwives and six by the neighbors and family).[28] In rural districts in Pennsylvania, it is estimated that there are annually 100,000 births in districts in which there are no hospitals and with very few, poorly prepared, underpaid and over-worked doctors available for the service.[29]

The large number of births attended by untrained midwives makes the situation even more serious. According to careful estimates 40 per cent of all the births in this country are attended by midwives.[30]

[25] *The Visiting Nurse Service Conducted by the Metropolitan Life Insurance Co., for the Benefit of Its Industrial Policy Holders,* 1915, p. 5.

[26] New York States Charities Aid Association, *loc. cit.,* pp. 17, 93, 97.

[27] *Ibid.,* p. 18.

[28] *Ibid.,* p. 53.

[29] James P. Warbasse, "The Socialization of Medicine," *Journal American Medical Association,* July 18, 1914.

[30] Grace Abbott, "The Midwife in Chicago," *American Journal of Sociology,* March 1915, p. 684.

"Health insurance represents a high type of public health measure of the utmost importance. It would provide the machinery for securing data in re morbidity that would serve as the groundwork for the most rational educational developments for the prevention of sickness among our industrial workers. It places a premium upon health."—American Medicine (Burlington, Vt.), March, 1916.

Mid-wives practising in New York state have been found by inspectors of the New York State Department of Health to be of three classes: the competent trained woman, the partially trained midwife who has been instructed by a physician or by another midwife, and the wholly untrained woman. The latter was "in greatest demand because she was cheap and did not annoy her patients with cleanly precautions."[31] Personal interviews with 500 midwives in New York City in 1906 disclosed the fact that less than 10 per cent could be classed as capable and reliable while the remaining 90 per cent were "hopelessly dirty, ignorant and incompetent."[32] A study of 187 Chicago midwives showed that fifty had not gone beyond the fourth grade in school, and ninety-one had not advanced beyond the eighth.[33]

A forward step has been made in New York and Pennsylvania, where midwives are licensed, registered, and supervised. The system of inspection, however, has revealed that in New York many unlicensed midwives are practising, unknown to the local authorities since they do not report the births attended. In one county where ten midwives were licensed fifteen were found who were unlicensed, the latter group having delivered nearly twice as many women as the licensed midwives. The unlicensed women are frequently found in the most out of the way places in which it would be impossible to secure medical assistance if it were needed.[34] Other rural districts lack even this provision, and mothers are dependent upon the care of neighbors or even of stray passersby.[35] The situation is not im-

[31] National Committee for the Prevention of Blindness, *First Annual Report*, November 1915, p. 36.

[32] J. Clinton Edgar, *The Education, Licensing and Supervision of the Midwife*, American Association for the Study and Prevention of Infant Mortality, 1915, p. 90.

[33] Grace Abbott, *loc. cit.*, p. 691.

[34] C. Josephine Durkee, "Midwife Inspection in State of New York," *New York State Journal of Medicine*, February 1916, p. 99.

[35] Carolyn Van Blarcom, *The Midwife in England*, 1913, p. 14.

"All health boards and similar institutions are vitally concerned in this subject of compulsory health insurance. All persons to whom the subject has been broached appear to be of the same opinion that universal insurance against sickness must come."—Ohio Public Health Journal, June, 1916.

proved, certainly, by the general inattention toward the problem. As late as 1913, in thirteen states[36] midwives' practice was unrestricted, while in fourteen states[37] there were no laws relating to their training, registration, or practice. An examination preceding the granting of a state license to practise was required in only twelve states.[38]

4. Facilities for Laboratory Diagnosis and for Consultation between Specialists Are Demanded by the Advances in Modern Medicine.

The progress of modern medicine has vastly increased the technical and laboratory equipment necessary for the proper diagnosis and treatment of disease, and has made medicine a cooperative profession. The requisite appliances for laboratory, X-ray, and surgical service are beyond the reach of the individual doctor, even if he is practising among the well-to-do.[39]

As a result, says Commissioner Haven Emerson, of the Department of Health, New York City:

> No individual physician without unusual resources can command for his patients the service of supporting experts and special data necessary to arrive at a thorough opinion of his patient's condition. . . . The problem is one of detection of as yet unsuspected early indications and susceptibilities, approaching deviation from the normal limits of individual variation, tendencies to degeneration, chronic diseases of nutrition, progressive departure from safety in various functions. To give an opinion takes a much higher grade of diagnostic skill, a greater degree of cooperation among physicians skilled in specialities, than does the practice of medicine

[36] Arizona, Arkansas, Florida, Georgia, Idaho, Kentucky, Maine, Mississippi, New Mexico, South Carolina, Tennessee, Vermont, and West Virginia.

[37] Alabama, California, Delaware, Massachusetts, Michigan, Nebraska, New Hampshire, North Dakota, Oklahoma, Oregon, Rhode Island, South Dakota, Texas, and Virginia.

[38] Connecticut, Illinois, Indiana, Louisiana, Maryland, Minnesota, Missouri, New Jersey, Ohio, Utah, Wisconsin and Wyoming.

[39] Michael M. Davis, Jr., "The Medical Organization of Sickness Insurance," *Medical Record,* January 8, 1916.

"We believe it is no more than simple justice that men and women who devote their working lives to the telephone service should be assured of some income when they are sick or come to old age. . . . If justice demands this, its cost is a fair charge against the business and so we regard it."—Board of Directors, American Telephone and Telegraph Co.

upon the sick. . . . Cooperation is necessary for efficient service to the public.[40]

Moreover, "the field of medical knowledge and the technique of practice in medicine and surgery," according to Michael M. Davis, Jr., of the Boston Dispensary, "have become far too large and complicated to be mastered by any one man. Specialists in a great variety of medical branches have been created."[41]

The well-equipped hospital and dispensary to-day afford facilities for cooperation in the use of equipment and for consultation among specialists, or "group diagnosis." The latter is also available in practice among the well-to-do. But if the advantage offered by modern medicine are to be brought within reach of all, they must clearly be extended, especially in the smaller cities. For instance, a recent study of health departments in 227 cities showed that it was only the eighteen cities of 300,000 population or over which were in all cases provided with a diagnostic service through the local board of health, while but fifty-one of the 103 cities of 25,000 to 50,000 had a similar service.[42] A further extension will undoubtedly be needed if the facilities for treating disease are to keep pace with the probable advances in medical knowledge itself.

[40] Haven Emerson, *Weekly Bulletin of the Department of Health, City of New York,* March 25, 1916.

[41] Michael M. Davis, Jr., "The Medical Organization of Sickness Insurance," *Medical Record,* January, 8, 1916.

[42] Franz Schneider, Jr., *loc. cit.,* p. 11.

"It would seem reasonable to infer that both the medical profession and the people have much to gain and nothing to lose by adopting compulsory sickness insurance."—Boston Post, February 13, 1916.

III. MORE EFFECTIVE METHODS ARE NEEDED FOR MEETING THE WAGE LOSS DUE TO ILLNESS.

"The poor," declares a mid-western social welfare organization, impressed by ill health as a cause of poverty, "are those whom sickness has halted in their daily tasks."[1] Unless some means more effective than any yet in force in this country is devised for protecting the wage-earner against the consequent stoppage of income, illness must be expected to produce in the future as in the past its yearly harvest of destitution and demoralization.

1. The Wage Loss Due to Illness Amounts to Millions of Dollars Annually.

In the Rochester sickness survey it was estimated that at the rate of $2 a day the annual wage loss in that city from illness is $1,288,000.[2] In Dutchess County the wage loss during illness and the cost of medical treatment for a period of about sixteen months reached, it was calculated, at least $412,000.[3] At the rate of $1.50 for six out of each seven days of disability, the country's wage loss every year from this one cause is, according to the estimate of the American Association for Labor Legislation, more than $366,000,000.[4] The investigators for the federal Commission on Industrial Relations calculated that the yearly wage loss to 30,000,000 workers throughout the country at $2 a day is $500,000,000.

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[1] Social Welfare Association, Grand Rapids, Mich., *Poverty: A Preventable Social Waste*, 1914, p. 5.

[2] Lee K. Frankel, "Community Sickness Survey," p. 435.

[3] State Charities Aid Association, *loc. cit.*, p. 3.

[4] American Association for Labor Legislation, "Memorial on Occupational Diseases," *American Labor Legislation Review*, January 1911, p. 127.

"Resolved, That the Social Welfare Conference of Buffalo, representing forty-three charitable institutions, favors the passage of the health insurance law. It believes that this law would lessen the amount of disease which is one of the chief causes of poverty, and would also help in creating better health conditions."—Social Welfare Conference of Buffalo, N. Y., February 12, 1916.

Wages of Industrial Workers in Representative States[1]

STATE	Average Yearly Income of Wage-Earners in Manufactures[2]		Number and Per Cent of Industrial Workers Receiving Given Wages[3]							
	Av. No. Wage-Earners in State	Av. Wage per Year	No. Receiving $10 a Week or Less		Per Cent of Total		No. Rec'ing $15 a week or less		Per Cent of Total	
			Men	Women	Men	Women	Men	Women	Men	Women
New Jersey	326,223	$520	123,599 (Week of maximum employment)	85,235	46.8	91.0	231,036	93,215	87.4	99.6
New York	1,003,981	555	134,001	95,281	42.1	88.2	240,850	106,188	75.6	98.3
Massachusetts	584,559	515	159,132 (18 yrs and over)	152,977	35.6	80.6	323,460	184,979	72.4	97.5
Kansas	44,215	585	20,694 (Week of maximum employment)	3,084	36.9	93.1	47,097	3,301	84.0	99.7
Iowa	61,635	527	12,313 (Week of maximum employment)	8,670	25.3	92.0	42,439	9,380	87.1	99.6
Ohio	446,934	548	66,553 (18 yrs and over, week of maximum employment)	79,276	11.6	82.4	325,273	94,192	56.7	97.9

[1] Data for workers 16 or over, unless otherwise stated.

[2] Thirteenth Census of the United States, 1910, Vol. IX, Manufactures.

[3] New Jersey Statistics of Manufactures, 1913, pp. 25, 26; New York Census of Manufactures for 1904, State Department of Labor *Bulletin No.* 37, 1904, p. 199; Massachusetts Statistics of Manufactures, 1913, p. XXXII; Kansas Department of Labor and Industries, *Report for 1914*, p. 29; Iowa Bureau of Labor Statistics, *16th Biennial Report*, 1913, p. 25; Ohio Industrial Commission, *Bulletin*, Vol. II, No. 4, Sept. 15, 1915, pp. 26-27.

2. Savings of Wage-Earners Are Insufficient to Meet This Loss.

Low wages, barely sufficient to supply the necessaries of daily life, are inadequate to meet the wage loss due to illness. The rate of wages paid to the workers in industrial establishments is seen in the table on the opposite page which gives both the average annual income in representative industrial states, and the distribution of workers in those states by weekly wage groups. From evidence such as this Dr. B. S. Warren and Edgar Sydenstricker of the United States Public Health Service conclude:

> Without taking into consideration the loss of working time for any cause, it has been found that during recent years in the principal industries of the United States between one-quarter and one-third of the male workers approximately eighteen years of age and over earned less than $10 a week, from two-thirds to three-fourths earned less than $15 a week, and only about one-tenth earned more than $20 a week. In textile manufacturing and some other industries the wage level was much lower. . . . It appears that in the principal industries fully one-fourth of adult male workers who are heads of families earned less than $400; one-half earned less than $600, four-fifths earned less than $800. . . . Statistics of total incomes of wage workers' families point to the conclusion that the average total annual family income in the principal manufacturing and mining industries has been between $700 and $800, in recent years. . . . The conclusion is also indicated that one in every ten or twelve workingmen's families had at the time of the investigations an annual income of less than $300 a year; that nearly a third had incomes of less than $500, and over one-half had incomes of less than $750 a year.[5]

Obviously such wages will not permit sufficient savings to live on during prolonged periods of illness. Of 25,440 families whose budgets were studied by the United States Bureau of Labor, 50 per cent reported an average surplus of $120; 16 per cent reported an average deficit of $65; while the remaining 34 per cent reported neither a

[5] B. S. Warren and Edgar Sydenstricker, *loc. cit.*, pp. 33-34.

"Sickness, like a two-edged sword, cuts both ways. It costs the worker his chance to earn wages. On the other hand doctors' bills pile up against him when he is down and helpless . . . The proposed system is intended to save the worker from the evil consequences that often come to him who fails to call a physician because he feels he can not afford to pay for a doctor's or surgeon's services."—Elizabeth (N. J.) Journal, May 1, 1916.

surplus nor a deficit.[6] The accumulations of 667 women in New York City department stores were reported to the New York Factory Investigating Commission. Of this number but 145, or less than one-fourth, had been able to lay by for the future. "On a weekly wage of less than $8," states Frank H. Streightoff, "it seems practically impossible to save in New York City; scarcely more than one-eighth in any earnings group below this sum succeeded in saving."[7] In a study undertaken for the Russell Sage Foundation it was found that savings existed in but 15 per cent of families with an income of $600; in 20 per cent of the $700 families; in 38 per cent of the $800-$900 families; in 23 per cent of the $900 group; and in 45 per cent of the $1,000 class. Nearly one-half of the cases of borrowing reported occurred in the $600 income group, and one-fourth occurred in the $700 division.[8]

But individual savings, even if wages were high enough to permit of a generous margin, do not fully meet the requirements of all situations. The uncertainty as to when sickness may overtake any one person, or as to how long it may last, makes it difficult for an individual to protect himself completely through this single-handed method. For this catastrophe, unpredictable to the individual, insurance constitutes the only effective provision. The uncertainty disappears in large groups among whom a definite percentage may be expected to be ill each year. A fund accumulated by a group with such knowledge will be able to meet fully the cost of each case of sickness and will simultaneously distribute the cost throughout the group.

In the absence of either savings or insurance, many who should be at home or in a hospital receiving medical care are forced to

[6] *Eighteenth Annual Report of the United States Commissioner of Labor*, 1903, "Cost of Living and Retail Prices of Food," pp. 366, 367.

[7] Frank H. Streightoff, "Report on the Cost of Living," *Fourth Report of the New York Factory Investigating Commission*, 1915, Vol. IV, p. 1574.

[8] Robert C. Chapin, *The Standard of Living in New York City*, 1909, pp. 233-243.

"Very little poverty comes from the 'vices' of which we [illegible]o prate in our charity organization conventions. It is the man w[illegible]gets sick, lies ill in a hospital, sees his savings go and knows that his family at home needs food, who feeds the ranks of poverty and inefficiency."—Lee K. Frankel, Sixth Vice-President, Metropolitan Life Insurance Company.

continue their daily grind. An official report, for instance, presents the case of Miss B., who "is very little and thin, pinched looking and extremely nervous. She has been ill several times but has kept on working. 'You see,' she said, 'I have no one to fall back upon and even if I feel sick I can't be sick. I have to keep going for there is no one to help me.' "[9]

Others seek to make good the loss by taking in lodgers, by sending the children to work, or by lowering their standard of living in other ways. Many apply for charity. Says the same report, speaking of one working woman's experience, "practically every week, in her factory, there is either a collection or a raffle for the benefit of some worker who is sick, who has no resources, and who, therefore, is an object of the charity of her fellow employees. This custom is really of considerable significance as an indication of how few are able to accumulate for times of emergency."[10] It is also significant as showing the tendency of workers voluntarily to protect themselves by insurance, even though the type of insurance chosen be a crude one.

A federal study of 31,481 charity cases among both immigrants and native born in forty-three cities showed that illness of breadwinner or other members of the family was "the apparent cause of need"[11] in 38.3 per cent of the cases, while accidents were a factor in but 3.8 per cent of the total applications for aid. (See diagram on opposite page.) At the New York legislative hearing on the health insurance bill in 1916 it was shown that 37 per cent of the families assisted by the New York City Charity Organization Society are dependent because their wage-earners are disabled by sickness, while two-thirds to four-fifths of the expenditure of the New York Association for Improving the Condition of the Poor is for relief

[9] Esther Packard, "Living on Six Dollars a Week," *Fourth Report of the New York State Factory Investigating Commission,* 1915, p. 1690.

[10] Frank H. Streightoff, *loc. cit.,* p. 1576.

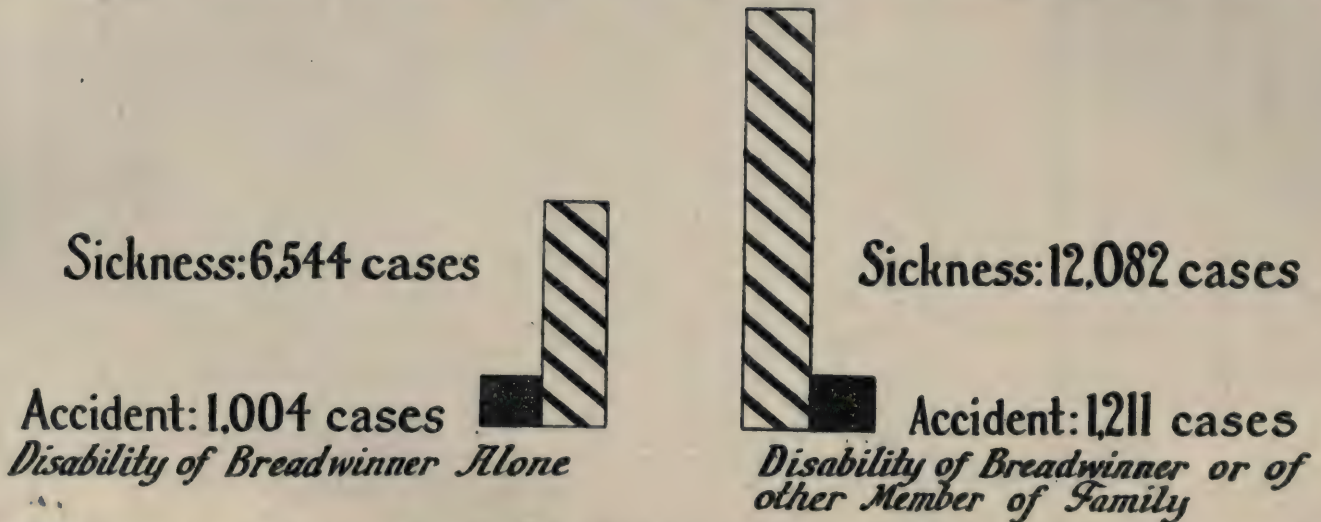
[11] *Report of the Immigration Commission,* 1909, Senate Document 665, 61st Congress, 3rd session, Vol. 34, p. 333.

"Experience under workmen's compensation for industrial accidents indicates the need of some system of insurance protecting workmen during periods of incapacity due to sickness."—John Mitchell, former President, United Mine Workers of America; Chairman, New York State Industrial Commission.

ACCIDENT AND SICKNESS AS FACTORS IN PRODUCING DEPENDENCY

Adapted from a study of 31,481 Charity Cases by the United States Immigration Commission, 1909

Sickness was a factor in 12,082 cases, or 38.3% of the total number
Accident was a factor in 1,211 cases, or 3.8% of the total number


Sickness: 6,544 cases
Accident: 1,004 cases
Disability of Breadwinner Alone
Sickness: 12,082 cases
Accident: 1,211 cases
Disability of Breadwinner or of other Member of Family

Sickness is a factor in 6 ½ times as much dependency as is industrial accident. The State requires insurance against industrial accident but not yet against sickness, a more urgent need.

necessary because of illness. In Buffalo, N. Y., it has been the experience of the Charity Organization Society "that sickness is more serious in our work for the poor than anything else. It far exceeds unemployment as a cause of poverty. Last winter, for instance, when the industrial depression was so huge, we paid out $13,646 on account of unemployment, and $29,275, or more than twice as much, to families in which there had been sickness during the year."[12]

America evidently presents no exception to the finding of Mr. and Mrs. Sidney Webb, that "In all countries, at all ages, it is sickness to which the greatest bulk of destitution is immediately due."[13]

3. Existing Systems for Insuring against the Wage Loss Are Not Fulfilling Requirements.

As opposed to direct saving, efforts have been made to meet the wage loss of illness through various forms of insurance. This method has the marked advantage, as employers and workmen have seen, that a small payment by each man in a group will provide for those affected by the catastrophe more effectively than savings by each individual, at a smaller per capita expenditure. The frequency with which sickness visits the home makes it necessary to make systematic provision for this almost certain financial loss. In the words of Haven Emerson, Commissioner of the New York City Department of Health:

> It is important to emphasize the advantages that may be expected from the supplying of funds to a family during illness. The continuance of nutrition is the most fundamental thing we must provide for. A tree will reveal in its rings of growth the lean and the fat years. So will the children of a community. Last year was a very lean year among the poor of New York, and we got a very large percentage of diseases among children, a great many respiratory diseases. These children were being starved

[12] Frederick Almy, in *Buffalo Times*, January 31, 1916.

[13] Sidney and Beatrice Webb, *The Prevention of Destitution*, 1911, p. 15.

"Your committee believes that the voluntary method of treating sickness insurance in industry is the higher and better method; but against this belief we know that there are employers who would not comply with the voluntary plan and provide for sick benefits to their incapacitated employees."—Committee on Industrial Betterment, National Association of Manufacturers.

into sickness. If one can assure the children, as they are growing up, continuous nutrition, we are going to go far toward health.[14]

A number of methods of providing insurance against illness—such as establishment funds, commercial health insurance, fraternal insurance, and trade union benefit funds—have been tried in this country, with uniformly unsatisfactory results as far as the mass of wage-earners is concerned.

The term "establishment fund" is commonly used in the United States to denote a benefit fund limited to the employees of a single industrial establishment or organization. As with other voluntary forms of health insurance in this country, the exact development which these funds have reached to-day is not precisely known. But that they are the exception rather than the rule among even important manufacturing plants such as are members of the National Association of Manufacturers is shown by the response to a recent questionnaire sent out by that organization. Out of 564 manufacturers sufficiently interested in sickness insurance to reply, only 144, or 25 per cent, had mutual benefit funds or other provision for sickness.[15] A similar inquiry by a manufacturer in 1913 brought out like results. Out of 500 prominent manufacturing establishments addressed, about 200 did not reply at all and only 110 of the remainder had such funds.[16] They are most common among railroad and mining employees, because of the hazardous nature of both occupations and the isolation of many mining communities, which renders combined action imperative if any medical care is to be secured.

The opportunity for workers to insure themselves against sickness by commercial health insurance on the industrial plan which is now available has yielded no better results. All available evidence goes to show that industrial health insurance is limited in extent and is

[14] Haven Emerson, *American Labor Legislation Review*, March 1916, p. 27.

[15] National Association of Manufacturers, *Report of Industrial Betterment Committee*, May 1916, p. 11.

[16] W. L. Chandler, "Sickness Benefit Funds among Industrial Workers," *American Labor Legislation Review*, March 1914, p. 73.

"Compulsory workmen's insurance has raised the working classes in Germany in respect to health, economy and standing in the community, and it is clear that, with their aid only, Germany has maintained her position in the markets of the world."—Bulletin of the American Chamber of Commerce in Berlin, December, 1915.

developing very slowly. In New York in 1914 four insurance companies received $29,223,400.11 premiums for industrial life insurance,[17] whereas the total premiums paid commercial companies for all forms of health insurance in the same state and year were only $1,379,915.[18] The larger part of even this comparatively small sum undoubtedly came from the business and professional, not from the wage-earning classes, since the more common forms of this insurance have relatively high premiums, payable annually or quarterly, which are entirely unsuited to the needs of wage-workers. In 1911 an authoritative estimate of the relative extent of industrial health insurance, which is based on small weekly or monthly premiums, placed it at not more than 20 per cent of the total.[19] Among the so-called "mutual sick benefit associations," the relative number of workingmen is perhaps larger, but in the whole United States in 1914 these companies had a total income of but $7,246,069[20] and according to the probably inaccurate figures available, a total membership of only slightly over 1,000,000.[20] Moreover, though they had on the whole made considerable gains since 1901, the earliest year for which figures are at hand, their growth was subject to decided fluctuations. Membership numbered some 842,000 in 1909 but fell off for the next three years until it reached 796,000 in 1912; it rose again to 1,563,000 in 1913, but had once more declined to 1,072,000 in 1914.

According to Mr. R. P. Shorts, President of the Convention of Health and Accident Underwriters, the organization covering the commercial health and accident field, there are to-day throughout the country about 180 insurance corporations, associations, and fraternal societies which have some hundreds of thousands of industrial accident and health insurance policies in force. The business which it

[17] *Report of the New York Superintendent of Insurance,* 1915, Part II, p. xliv.

[18] *Insurance Year Book,* 1915, p. A-319.

[19] I. M. Rubinow, *Social Insurance,* 1913, p. 296.

[20] *Insurance Year Book,* 1915, p. A-388.

"It is a long deferred essential to our economic welfare. To wage earners health insurance is next in importance to compensation for industrial accidents. Both should be provided."—James Duncan, President, Granite Cutters' International Association of America; First Vice-President, American Federation of Labor.

has taken twenty-five years to develop and which it should be noted includes fraternal societies as well as commercial companies makes but a poor showing beside the 5,931,000 industrial life policies furnished the residents of the one state of New York alone by four companies,[21] and is insignificant in comparison with the more than 31,000,000 industrial life policies outstanding in the United States in 1914.[22]

Moreover there are indications that even the limited membership of industrial health insurance enterprises is not held permanently, but that the lapse rate is very high. Among the mutual sick benefit associations just mentioned the number of certificates issued in any one year is almost as large as the number in force at the end of that year.[23] In 1901 the number of new certificates was even considerably greater than the number in force at the end of the year; in 1914 it was about nine-tenths as great. Although similar figures for the other sorts of commercial health insurance are not at hand, there is every reason to believe that the high lapse rate found in industrial life insurance is repeated in industrial health insurance.[24]

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[21] *Report of the New York Superintendent of Insurance,* 1915, Part II, p. xliv.

[22] *Insurance Year Book,* 1915, p. 235.

[23] *Statistics of Mutual Sick Benefit Associations.* (Insurance Year Book, 1915, p. A-388.)

Year	*No. of Companies*	*No. of Certificates Written During Year.*	*No. of Certificates in Force at End of Year*
1901	58	207,044	153,907
1906	102	430,197	584,038
1911	88	735,426	893,015
1914	122	935,230	1,072,664

[24] One of the largest of the industrial insurance companies testified before the Armstrong investigating committee in 1906 that one-third of the policies did not survive three months, that one-half are cancelled within a year and that nearly two-thirds lapsed within five years. (*Report of the Joint Committee of the Senate and Assembly of the State of New York to Investigate and Examine into the Business and Affairs of Life Insurance,* New York, 1906, Vol. VII, pp. 234, 235.)

"Illness as well as injury occasion a large economic waste to the company as well as to the employees on account of lost time, idle machinery, and ineffective work. It is to the direct interest of the company as well as to the individual to bring about a reestablishment of health, and consequently efficiency, by supplying the best conditions possible for recovery."—Howell Cheney, Cheney Brothers, Silk Mills.

A large amount of insurance is provided by so-called fraternal societies which combine, with certain social features and a semi-secret ritual, insurance on the mutual plan, generally by means of assessments. However, only a small fraction of this insurance covers sickness or temporary disability. On January 1, 1915, there were in the United States 179 fraternal associations with 7,700,000 "benefit members."[25] During 1914 the benefits of all kinds, including death, sickness, and old age, paid by these societies, totaled about $97,000,000.[26] Only thirty national organizations, having some 820,000 members, not all of whom carried health insurance, paid benefits for sickness in 1914 and this minority disbursed but $1,100,000, about 1 per cent of the whole fraternal insurance business for both sickness and accident claims. Over half of this amount was paid out by three societies.[27] It is true that many individual lodges of some large fraternal orders also pay benefits for sickness, but unfortunately no figures on the amount of these benefits or the members thus protected are available. Nor in comparison with other forms of fraternal insurance is there any tendency apparent toward an increase in health insurance among fraternal societies. In 1909, similar statistics show that 177 American fraternals with 6,400,000[28] "benefit members" paid out $77,000,000[29] for all kinds of benefits. Thirty-eight of these societies with 799,000 "benefit members" spent $856,000 for sickness and accident claims, which was 1.1 per cent of the total expenditure for benefits by all societies.[30] In addition certain secret orders, like the Masons and Odd Fellows, help their members during sickness but do not make insurance a feature.

The fourth method of voluntary health insurance which has de-

[25] *Statistics of Fraternal Societies,* 1915, pp. 197-199.
[26] *Ibid.* p. 205.
[27] *Fraternal Monitor Consolidated Chart,* 1915, pp. 3-31, 91.
[28] *Statistics of Fraternal Societies,* 1910, pp. 199-201.
[29] *Ibid.,* p. 207.
[30] *Consolidated Chart,* 1910, p. 3-33.

"I believe that public opinion is rapidly crystallizing in favor of both state and federal legislation, favorable to the enactment of laws devising a system of insurance against industrial diseases and I firmly believe that when this movement gets fairly started it will develop just as fast as the movement did for workmen's compensation for industrial accidents."—John Golden, General President, United Textile Workers of America.

veloped in America, namely, trade union benefit funds, is also very limited in extent. Of approximately 30,000,000 wage-earners in the country, not more than one-tenth are members of labor unions of any sort. Moreover, not all members of trade unions are covered by union sick benefit funds. During the year 1914-1915 twenty-nine international unions affiliated with the American Federation of Labor paid out $971,271.75 in sick benefits,[31] but the membership of these internationals comprises about 548,000, or not much more than a quarter of the entire membership of the federation. Similar relief was paid by some of the local unions in other trades.

In view of these facts, it is obvious that in America voluntary methods of insurance against the wage loss due to sickness are not adequately fulfilling requirements, and that the great majority of American industrial workers are to-day unprotected by health insurance. Moreover, the lowest paid workers who most need insurance are least likely to be protected. Whether voluntary insurance can reasonably be expected to develop in the future to meet the needs will be discussed in a later section.

[31] American Federation of Labor, *Proceedings of the Thirty-fifth Annual Convention*, 1915, p. 30.

"The burden of sickness now borne entirely by the workman, it is estimated, is responsible for fully one-third of the poverty of this country."—Dr. Henry J. Harris, Chief of Documents, Congressional Library.

IV. ADDITIONAL EFFORTS TO PREVENT SICKNESS ARE NECESSARY.

Important as are measures for the more adequate medical care and financial protection of sick wage-earners, all such measures remain incomplete and wasteful unless accompanied by energetic efforts for the prevention of sickness. Said an expert committee in 1911:

"It is a generally accepted principle of modern sanitary science, that a large amount of sickness in industry or otherwise is preventable, and that the average duration of life can be materially prolonged by deliberate and rational methods of personal, social, and industrial hygiene."[1] After careful computation this same committee framed the conservative estimate that the number of days of sickness per annum (more than 284,000,000 in all) could, by deliberate efforts, be diminished by 25 per cent, or 71,000,000, and that the resulting total economic gain to the nation might be estimated at not less than $193,000,000 per annum.

1. The Method of Factory Legislation and Inspection Has Proven Insufficient to Secure Hygienic Conditions of Work.

For nearly four decades American states have been attempting to secure healthful conditions of work through the method of factory legislation and inspection, with only partial success. Much of the legislation was unscientific and riddled with loopholes. Much was rendered ineffective by perfunctory or incapable inspectors. Even when inspectors inspected thoroughly and entered prosecution for violation of the statutes, they often met with small encouragement from the courts. According to a federal investigator, "A study of the annual reports of the chief factory inspector [in New York]

[1] American Association for Labor Legislation, "Memorial on Occupational Diseases," *American Labor Legislation Review,* January 1911, p. 126.

"Under the proposed measure it will be to the interest of both employer and the employed to ward off disease by preventive measures. They will save money by preventing illness as much as possible."— Ithaca (N. Y.) Globe, February 5, 1916.

for a number of years shows many instances in which the courts failed to support the inspectors. Thus in the report for 1907 it is shown that in about one-half of the cases in which inspectors had secured convictions the court remitted the fine, thus letting the offender off without punishment. In most of the other cases only the minimum fine was imposed."[2]

Under such conditions laws for factory hygiene are likely to become dead letters. Many states require the more or less thorough removal of "gases, vapors, dusts, or other impurities injurious to health" which are generated in industrial processes. Yet in one of these states, Massachusetts, in twenty-four out of thirty-three establishments investigated where "injurious or irritating dust or fumes" were noticeable in workrooms no removal devices were installed; in New Jersey ten out of thirteen similarly dangerous establishments were found unprotected; in Illinois, twenty-three out of thirty-one.[3] In view of these findings the conclusion in 1912 of the New York Factory Investigating Commission, "that the present system of factory inspection is totally inadequate,"[4] is not surprising.

One main trouble with the system, however, is that it does not enlist the interested cooperation of either the employer or the employee. As with accident prevention before the days of workmen's compensation, the industrial sanitation statutes look well on the books, but exert little influence on actual factory conditions. No considerable progress can be hoped for until a method is devised which will directly stimulate both workman and employer to reduce the risk of occupational illness to the minimum.

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[2] Hugh S. Hanna, "Labor Laws and Factory Conditions," *Report on the Condition of Woman and Child Wage-Earners in the United States,* Senate Document 645, 61st Congress, 2nd Session, Vol. XIX, p. 44.

[3] *Ibid.,* pp. 451, 467, 476.

[4] *Preliminary Report of the New York State Factory Investigating Commission,* 1912, Vol. I, p. 66.

"Self interest is probably the strongest motive with man, and if it can be harnessed into activity against industrial diseases, there doesn't seem to me to be any doubt that it would be a very powerful factor in the prevention or control of such diseases."—Andrew Furuseth, President, International Seamen's Union of America.

2. Infectious Diseases Are Not Being Thoroughly Prevented.

Tuberculosis in its various forms cost more than 96,000 lives in 1914 in the registration area, which contains about two-thirds of the country's population. This one preventable disease, according to estimates made for the National Conservation Commission in 1909, annually affects 500,000 individuals;[5] while Frederick L. Hoffman somewhat later placed the cases of pulmonary tuberculosis among wage-earners at 752,000.[6] Of the deaths from tuberculosis, it was estimated for the Conservation Commission that 75 per cent are postponable and in that sense may be considered "preventable."[5]

Typhoid fever in 1914 was responsible for 10,000 deaths in the registration area, and for every death there are, according to the Conservation Commission's report, eight cases of illness, averaging seventy-five days of incapacity each.[5] But this is not the only loss. Professor Sedgwick has said, "Hazen's theorem asserts that for every death from typhoid fever avoided by the purification of a polluted public water supply two or three deaths are avoided from other causes . . . conspicuous among these are pneumonia, pulmonary tuberculosis, bronchitis, and infant mortality." Of these typhoid deaths 85 per cent were considered "preventable" in 1909.[5] Each year, also, "there are probably 3,000,000 cases of malaria in the United States, most of which are in the South. This is practically all preventable."[7] "As it is a preventable disease, its continued prevalence is a reproach to the people, and its eradication would be a good money investment," says the Journal of the American Medical Association.[8] Hookworm, another preventable disease, "extends over the whole South, and is responsible for a large part both of the sickness (the so-called 'laziness') and of the poverty of the 'white trash.' . . Most striking is the fact that the disease is easily preventable through the introduc-

[5] National Conservation Commission, *Report on National Vitality; Its Wastes and Conservation*, prepared by Irving Fisher, 1909, pp. 34, 35, 105.

[6] Frederick Hoffman, "Care of Tuberculous Wage-Earners in Germany," United States Bureau of Labor Statistics, *Bulletin No. 101*, p. 19.

[7] National Conservation Commission, *loc. cit.*, p. 35.

[8] *Journal American Medical Association*, February 5, 1916.

"The total gain to the whole community from getting effective medical care to the whole population before diseases take root, before infections spread, would be immeasurable."—Prescott (Ariz.) Miner, February 22, 1916.

tion of sanitary measures as well as curable by the proper (drug) treatment of the present victims. It has been practically eradicated from Porto Rico."[9]

The four contagious diseases of measles, scarlet fever, whooping cough, "diphtheria and croup," caused a loss of 27,000 lives during 1914 in the registration area alone. The failure to make more rapid headway against these diseases may be due in part to failure to register and thus properly to control the cases, and so to prevent further infection. For instance, in the survey of sickness in Dutchess County, N. Y., previously cited, 176 cases of measles were found, of which only seventy-six had been quarantined.[10] "Although most states have laws or regulations requiring the reporting of cases of certain diseases," say the United States *Public Health Reports,* "it is not believed that at present any state is enforcing its requirement."[11]

3. Deaths from Degenerative Diseases Are Rapidly Increasing.

One of the alarming situations presented by the United States mortality statistics is that degenerative diseases of middle life are not decreasing, but are even rapidly increasing. "Whereas the expectation of life at birth is now about ten years greater than it was thirty years ago," states Charles F. Bolduan of the New York City Board of Health referring to figures for that city, "the adult of 40 years or over actually has a shorter expectation of life than formerly, the decrease amounting to a year or more according to the age period."[12] Other investigators have reached the same

[9] National Conservation Commission, *loc. cit.,* p. 35.

[10] State Charities Aid Association, *loc. cit.,* p. 4.

[11] United States *Public Health Reports,* June 16, 1916, p. 1524.

[12] Charles F. Bolduan, "Chronic Diseases of the Heart, Kidneys, and Arteries from the Standpoint of Etiology, Prevalence, Mortality, and Prevention," *Monthly Bulletin of the Department of Health, City of New York,* April, 1916, pp. 91-92.

"Health insurance will give the American business man a direct, pecuniary interest in combating tendencies toward disease in the general population. There is no more efficient organizer in the world than the American business man. If once it is proved to him that he is justified in turning his talents to the solution of problems of public health, we may expect rapid progress toward the removal of conditions destructive of the stamina of the people."—New Republic, March 25, 1916.

conclusion. For instance, Professor Irving Fisher says, "Here [*i.e.* in Massachusetts] where the death rates for all age periods under forty have materially decreased, the later periods of life have suffered progressively in mortality rate." A comparison of the Massachusetts life tables for 1877-1882 with those of 1910 shows that while the expectation of life is now greater for males under twenty-five and for females under thirty-five than it was at the earlier date, for those over the given ages it has decreased from half a year to more than two years. The following table presents the comparison in detail:

EXPECTATION OF LIFE IN MASSACHUSETTS, 1877-1910
(White and Colored)

AGES	MALES				FEMALES			
	1877—1882[1]	1893—1897[2]	1910[3]	Increase or Decrease in Expectation of Life, 1877-1910	1877—1882[1]	1893—1897[2]	1910[3]	Increase or Decrease in Expectation of Life, 1877-1910
0	41.74	44.09	49.33	+7.59	43.50	46.61	53.06	+9.56
1	49.84	52.18	56.12	+6.28	50.24	53.58	58.79	+8.55
2	52.17	53.46	56.75	+4.58	52.35	54.79	59.31	+6.96
3	52.76	53.54	56.43	+3.67	52.89	54.83	58.95	+6.06
4	52.93	53.30	55.90	+2.97	53.00	54.62	58.34	+5.34
5	52.78	52.88	55.20	+2.42	52.88	54.17	57.65	+4.77
10	49.92	49.33	51.14	+1.22	50.04	50.70	53.56	+3.52
15	45.86	45.07	46.71	+0.85	46.08	46.53	49.11	+3.03
20	42.17	41.20	42.48	+0.31	42.78	42.79	44.85	+2.07
25	39.04	37.68	38.51	−0.53	39.78	39.29	40.77	+0.99
30	35.68	34.28	34.55	−1.13	36.70	35.85	36.78	+0.08
35	32.32	30.87	30.72	−1.60	33.63	32.43	32.90	−0.73
40	28.86	27.41	26.97	−1.89	30.29	29.00	29.04	−1.25
45	25.41	23.93	23.34	−2.07	26.95	25.54	25.25	−1.70
50	22.02	20.53	19.79	−2.23	28.50	22.10	21.55	−1.95
55	18.63	17.33	16.45	−2.18	20.05	18.81	17.99	−2.06
60	15.60	14.38	13.42	−2.18	16.91	15.74	14.79	−2.12
65	12.57	11.70	10.81	−1.76	13.77	12.90	11.94	−1.83
70	10.32	9.34	8.58	−1.74	11.30	10.36	9.49	−1.81
75	8.08	7.37	6.65	−1.43	8.83	8.29	7.30	−1.53
80	6.86	5.70	5.07	−1.79	7.37	6.56	5.49	−1.88
85	5.63	4.31	3.88	−1.75	5.91	5.07	4.17	−1.74

[1] *U. S. Census,* 1880, Vol. XII, Part II, "Mortality and Vital Statistics," p. 775.
[2] Massachusetts State Board of Health, *Report No. 30,* 1898, pp. 822—825.
[3] U. S. Bureau of the Census, *United States Life Tables,* 1910, pp. 50-53.

"In my judgment the time is not far distant when a system of health insurance will be devised by the legislatures of the various states and by the federal government which will meet the needs of our present social life."—John Mitchell, former President, United Mine Workers of America; Chairman, New York State Industrial Commission.

Summing up the matter for the country at large, Frederick L. Hoffman says:

> There is, of course, no question whatever that the American death rate, using the term in a very comprehensive sense, has substantially declined within the last fifty years, but it is equally evident that this decline has been at the youngest ages, and not during the period of life which, economically, is of the greatest value. There is no doubt that the mortality of adult ages is still decidedly excessive.[13]

"In seeking to penetrate further into the reason for the increased mortality in the higher-age groups," says Dr. Bolduan, "Guilfoy in 1908 undertook a detailed analysis by age groups and disease, using as a basis a comparison of the New York City statistics for 1868 and 1907. His work left no doubt that the increased mortality was due principally to diseases of the heart, arteries, and kidneys, and to cancer. Exactly similar results were reported by Dublin in a paper presented before the American Public Health Association in 1913."[14] Following is Dublin's table:

DEATH RATE PER 100,000 POPULATION FOR CERTAIN CAUSES OF DEATH, MALE AND FEMALE COMBINED.

(*Registration States as Constituted in 1900.*)

Cause of Death	*1900*	*1910*	*Per cent Increase*
Cancer—all forms	63.5	82.9	30.6
Diabetes	11.0	17.6	60.0
Cerebral hemorrhage and apoplexy	72.5	86.1	18.8
Organic diseases of heart	116.0	161.6	39.3
Diseases of arteries	5.2	25.8	396.2
Cirrhosis of liver	12.6	14.4	14.3
Bright's disease	81.0	95.7	18.1
Total	361.8	484.1	33.8

In the twenty year period from 1890 to 1910 the mortality from the combined degenerative diseases in the registration area for all ages increased 41 per cent, divided as follows:

Heart and circulatory	46 per cent
Kidneys and urinary	50 " "
Apoplexy and nervous system	32 " "

[13] Quoted by Irving Fisher, *loc. cit.*, p. 26.

[14] Charles Bolduan, *loc. cit.*, p. 93.

"In addition to spreading the cost of the poor man's illness over a wide field, health insurance acts as a shield against the worry and fear of contingencies which lower the workers' economic efficiency and independence. . . . It ought to be generally adopted."—Chicago Daily News, February 17, 1916.

The rising mortality from degenerative diseases is a purely American problem, unknown in England, Sweden, and other hygienically advanced European nations,[15] and one of vast importance to the American people, for according to the Life Extension Institute, "it indicates a decline in American vitality."[16] Dr. Rittenhouse adds,

> These slowly developing afflictions are not only reducing the working, productive period of life but they are lowering the working capacity of the individual often before he realizes it, or recognizes the cause. They are responsible for accidents, for damaged machines, spoiled goods, and other costly errors. They are the concealed enemies of alertness, accuracy, and efficiency. Therefore, every employer, small or large is financially concerned in checking the ravages of this steadily advancing enemy.[17]

The significance of these impairments in the life of the nation is seen in the actual mortality figures. According to the federal Bureau of the Census, in 1914 in the registration area 52,420 deaths were due to cancer, 51,272 to apoplexy, 67,545 to Bright's disease, 15,044 to diseases of the arteries, and 99,534 to diseases of the heart. Among the living, a large proportion have been found to be physically impaired. For instance out of 20,336 rejected applicants for life insurance 43 per cent were refused on the ground of the presence of or indications of the approach of these diseases.[18] Dr. S. S. Goldwater cites the results of physical examination of the employees of a New York City bank in which 100 per cent were found to be "on the sure road to diseases of heart, lungs, and kidneys, or blood vessels."[19] For the country as a whole Dr. Rittenhouse states:

> It is safe to say that there are constantly at least 15,000,000 adults in America who have one or more of these organic diseases in some stage

[15] E. E. Rittenhouse, "Increasing Organic Disease—The New Public Health Problem," *American Journal of Public Health,* November, 1915, p. 1133.

[16] *Life Extension Institute, What Is It—What It Does,* p. 17.

[17] E. E. Rittenhouse, *Protecting the Human Machine,* address delivered before the Board of Trade, Washington, D. C., April 27, 1915, p. 2.

[18] E. E. Rittenhouse, "Increasing Organic Disease—The New Public Health Problem," *American Journal of Public Health,* November 1915, p. 1133.

[19] S. S. Goldwater, "The Next Step in Preventive Medicine," Department of Health, City of New York, Reprint Series, no. 18, June, 1914, p. 5.

"The provision of medical care alone promises much for the prevention of sickness through detection of incipient diseases."—New York Sun, January 29, 1916.

of development. The period of development from the incipient to the serious stage of this class of disease may range from weeks to years, during which time they may be detected by occasional physical examinations and checked or cured if given proper attention. The most of these 15,000,000 people are drifting into these slowly developing and deferable organic diseases unknowingly. The state neither informs them or warns them.[20]

Dr. Goldwater asks, "In the light of such evidence as this, can it be maintained that preventive medicine is properly organized 'to curtail and if possible to prevent disease, to prolong existence, and to render life happier by means of improved physical conditions'?" Moreover, "These diseases, together with cancer and tuberculosis, are the despair of hygienists. If we do not know how to prevent them, we know at least how to recognize them in their earlier stages, long before the victims are incapacitated; and in a large percentage of cases we can postpone their serious development, promote the comfort of the individual, and prolong his working life."[21]

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[20] E. E. Rittenhouse, *loc. cit.*, p. 1130.

[21] S. S. Goldwater, *loc. cit.*, p. 5.

"Knowing from our close association with the masses the immense amount of good such a measure would accomplish in relieving want and distress during sickness, in removing the fear of such from those who can hardly in good health keep the wolf from the door, and also in relieving from public charity those who are forced to seek such when illness has incapacitated them from earning their livelihood, we believe this measure to be fully justified by the self-respect such a measure would instill."—John P. Coryell, Secretary, Central Labor Union, White Plains, N. Y.

V. EXISTING AGENCIES CANNOT MEET THESE NEEDS.

Not only are existing agencies for health insurance signally failing to measure up to the recognized needs for the cure, financial relief, and prevention of illness among wage-earners, but they are marked by inherent weaknesses which, as available experience has demonstrated, render them incapable of developing properly to meet those needs.

1. Charitable Institutions and Organizations Give No Evidence That They Can Provide an Adequate Solution.

Philanthropic medical and relief organizations and institutions cannot be expected to provide an adequate solution to the problems arising from illness of wage-earners, even if their extension were wholly desirable. One of their main obstacles consists in the financial difficulties with which they must constantly struggle. In 1902 it was pointed out that twenty great New York city hospitals had an annual deficit of $432,000. City payments covered less than half the cost of public charges cared for by these institutions and city finances were in such poor condition that no large increase could be hoped for from that source.[1] In 1915 the financial situation was still unsatisfactory. Four out of the five largest hospitals showed a total deficit of $119,000 for the year ending September 30, 1915. The payments by the city were no higher in proportion to the cost of care, and the condition of municipal finances continued to make any marked increase in the city's help unlikely. The amount raised for the hospitals by the United Hospital Fund had risen only from $83,000 in 1902 to $113,000 in 1915, and nine more hospitals shared in the distribution. Such an organization as the Instructive District Nursing Association of

[1] Frank Tucker, "The Financial Burden of New York's Hospitals," *Charities*, January 2, 1904, pp. 27-32.

"As an employer of labor, I am heartily in favor of this bill, as I think it would help workingmen to help themselves to an extent, without feeling the burden, and the little it would cost us as employers would compensate us in not seeing so much misery among those whom we have been associated with."—F. A. Reinhardt, Reinhardt Manufacturing Company.

Boston, which finds that "Without the help of some social reform which will produce money to pay for care during illness, health agencies can do little more,"[2] is facing a similar situation.

Relief societies, to which the worker must frequently turn when in financial distress through sickness, find it no easier than medical agencies to raise an adequate budget. The long-established Brooklyn Bureau of Charities reported for the prosperous year ending April 30, 1913, that "much more [money] will be needed to cope with the expanding needs . . . of this borough."[3] The Philadelphia Federation of Jewish Charities, in its report for the year ending April 30, 1911, states that its members "are hampered for money. . . . The situation calls for greater liberality."[4] All social workers know that the financial question is one of the most pressing problems of philanthropic work.

A second limitation of philanthropic efforts is that of distributing institutions in accordance witih the need and not merely in accordance with the whim of the giver. In an investigation of sickness in selected areas on the lower east and middle west sides of New York City in 1910, it was found that tuberculosis was approximately three times as prevalent in the latter neighborhood as in the former. Yet the east side district had three tuberculosis clinics to supply its needs while the west side district had but one. The report says that similar differences with a corresponding lack of provision for care were present with regard to other diseases.[5] After an extensive survey of the hospital situation in the smaller cities of the state, the New York Charities Aid Association remarked on the tendency not to provide for certain troublesome classes of diseases, namely contagious, alcoholic, and psychopathic cases.[6]

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[2] The Instructive District Nursing Association of Boston, *Thirtieth Annual Report*, year ending January 31, 1916, p. 27.

[3] *Thirty-fourth Annual Report of the Brooklyn Bureau of Charities*, p. 34.

[4] *Eleventh Annual Report of the Federation of Jewish Charities of Philadelphia*, 1911-1912, p. 12.

[5] *Report of the Committee of Inquiry into the Departments of Health, Charities and Bellevue and Allied Hospitals*, 1913, p. 528.

[6] State Charities Aid Association, *Hospital Needs in Poughkeepsie*, 1913, p. 11.

"The time is ripe to treble the effectiveness of the benefit fund idea by proper encouragement."—W. L. Chandler, Dodge Manufacturing Company.

But even if it were possible to obtain the money and the intelligent organization of charitable institutions necessary to supply the wage-earners' needs in time of sickness, the desirability of the method would be extremely doubtful. We might continue indefinitely to help cases of sickness by means of charitable relief without setting in motion any preventive measures which would reduce its amount. Then, too, the rank and file of wage-workers have a wholesome distaste for charity and are unwilling to avail themselves of it except as a last resort. The statement of the United Hospital Fund of New York City will be recalled that "Beyond question there are large numbers who need hospital treatment but fail to apply because they do not want to become objects of charity."[7] Such reluctance is worthy of encouragement rather than of discouragement, for it is in accord with the enlightened opinion of society as a whole that "alms-giving and alms receiving are degrading and demoralizing and that alms-giving should be restricted as far as possible." Attempts to meet the objection and to provide for those who can pay a little, but not the entire cost, through partially self-supporting clinics with low charges have been met by opposition from some quarters within the medical profession. Objection to evening pay clinics for those of modest means has been made both in Boston and New York on the ground that it would divert patients from family physicians. The New York County Medical Society has opposed the opening of such a pay clinic with $1 fees on the ground that it would be an unnecessary pauperization of individuals and an injury to the medical profession.

2. Establishment Funds Cannot Meet These Needs.

While many establishment funds are doing excellent work as far as they go, dependence upon the initiative and often upon the financial support of the employer will necessarily confine these funds to the progressive employer alive to his responsibilities to employees, leaving the great majority of wage-earners, and especially those most in need, without such protection. This is admitted by many employ-

[7] See p. 167.

"A large number of manufacturing concerns believe in the principle of sickness benefits for their employees to the extent of establishing voluntary systems in their particular plants."—Committee on Industrial Betterment, National Association of Manufacturers.

ers themselves. The industrial betterment committee of the National Association of Manufacturers reported:

> Your committee believes that the voluntary method of treating sickness insurance in industry is the higher and better method; but against this belief we know that there are many employers who would not comply with the voluntary plan and provide sick benefits to their incapacitated employees.[8]

Even in their limited field it must be recognized that in the absence of state regulation or control certain socially disadvantageous conditions are often present in connection with establishment funds. In some cases employees have no share in the management of the funds and in not a few such instances membership is nevertheless compulsory. Joseph P. Chamberlain of the Columbia Legislative Drafting Research Fund says of railroad sick benefit funds, "although in many cases the men and the directors of the companies jointly manage the associations, yet, in some benefit associations, and in almost all, perhaps actually all hospital funds, the men have no voice. They are docked for contributions; they are cared for when sick; but they have no seat in the committee which disposes of the money and passes on the accounts."[9] An investigation of 461 funds by the United States Bureau of Labor showed that a total of 90,000 out of 750,000 members had no voice in the management.[10]

Recent experience in New York state shows that in addition to its objectionably paternalistic character, a compulsory benefit fund controlled entirely by the employer may be subject to serious abuses. On the failure of a large New York City department store it was found

[8] National Association of Manufacturers, *Report of Committee on Industrial Betterment,* presented at the Twenty-second Annual Meeting, New York, May, 1916.

[9] Joseph P. Chamberlain, "Sickness Insurance and Its Possibilities in Mining and Railroading," *The Survey,* January 16, 1915, p. 424.

[10] *Twenty-third Annual Report of the United States Commissioner of Labor,* 1908, p. 390.

"They attempt to provide against it [sickness] in the only way known to them—by insurance with 'health insurance' companies. The cost is enormous for a negligible benefit. The only way this matter can be handled properly so that the most necessitous will be provided for is through universal compulsory state health insurance."—Hon. Royal Meeker, U. S. Commissioner of Labor Statistics; Secretary-Treasurer, International Association Industrial Accident Boards and Commissions.

that the funds of its benefit society, which was compulsory and wholly controlled by the firm, had been lost through their use to bolster up the business. Popular indignation at the situation was expressed in a law forbidding "compulsory contributions by means of deductions from wages, direct payment or otherwise of employees in mercantile establishments to benefit or insurance funds."[11]

Labor men and some economists also feel that since voluntary establishment funds are inevitably the exception and not the rule, there is grave danger lest they interfere with the mobility of labor, binding the worker to unsatisfactory conditions for the sake of the benefits. Their exact influence in this direction is naturally impossible of determination but recent reports of a strike in the metal trades give some weight to the theory. The promise of the company that all the men returning to work on a given date would retain all their priveleges in the benefit fund without penalty apparently proved an important factor in breaking the strike. Without reference to the merits of the controversy, the possible use of benefit funds in this way seems most undesirable from any social point of view. It has been suggested that this drawback could be overcome by voluntary federation and interchange of membership among several funds, but there is no tendency apparent to carry this idea into effect. Only one such federation is known to exist in the country, the Flint Vehicle Factories' Mutual Benefit Association of Flint, Mich., formed in 1901, and this is limited to one small city.[12]

The work of establishment funds in detecting and treating disease in early stages suggests the possibility of large-scale preventive efforts under universal health insurance. "The plan which some establishments are trying of having a corporation physician to examine the employees is a splendid aid to the fund by detecting many

[11] New York, Laws 1914, C. 320.

[12] Franklin V. V. Swan, "Industrial Welfare Work in Flint, Mich.," *The Survey*, July 18, 1914, p. 411.

"The cost of sickness or casualties falls mainly upon those who can least afford the loss. Since society has considerable to do with creating or continuing their industrial conditions, and since the state benefits from their industry and suffers from their misfortunes, it follows that state insurance forms self-protection to society."—Spokane (Wash.) Spokesman-Review, March 24, 1916.

cases needing treatment before they become critical or chronic" says W. L. Chandler, reporting on his investigation of establishment funds.[13] However, when the administration is in the hands of employers these preventive efforts can not obtain the full cooperation of employees and in all cases the efforts are limited by the lack of cooperation between various funds, which prevents them from drawing on the experience of the trade as a whole.

3. Commercial Health Insurance Cannot Be Developed to Meet These Needs.

Commercial health insurance, also, cannot well be developed to meet the demands of modern society for protection of wage-earners against illness and its consequences. Perhaps the most serious hindrance to the extension of this form of insurance is its necessarily high cost in proportion to the benefits received. In the District of Columbia, for instance, where approximately $500,000 is annually paid in health insurance premiums to agents who collect 10, 15, and 25 cents a week at the homes of policyholders, only $200,000 is paid out in benefits; the remaining $300,000 is largely devoted to the cost of securing business and of making collections. "These people," says Hon. Charles F. Nesbit, Superintendent of Insurance of the District of Columbia, "have to give up $1 for every 40 cents they get gack."[14]

Throughout the country a similar situation exists. In their examination of the fourteen principal companies writing industrial health and accident insurance, the National Convention of Insurance Commissioners found that the highest ratio of losses to premium payments was only 46 per cent and that the lowest was but 30 per cent.[15] Among "mutual sick benefit associations" conditions are little better.

[13] W. L. Chandler, "Sickness Benefit Funds among Industrial Workers," *American Labor Legislation Review*, March 1914, p. 74.

[14] Testimony before the Committee on Labor of the House of Representatives, April 6, 1916, on H. J. Res. 159, A resolution for the appointment of a commission to study social insurance and unemployment, p. 105.

[15] *Proceedings of the National Convention of Insurance Commissioners*, 1911, Vol. II, p. 95.

"It costs our people, as a community, nearly or quite as much for medical attention, support of the disabled, and of families directly, at the present time, as it would cost under an economically administered sickness insurance plan."—Miles M. Dawson, Consulting Actuary.

In 1914, the total amount paid for medical examiners (who sometimes give treatment), agents and "expenses of management," ($3,195,894) was nearly as much as the total amount paid to members for sick and other claims ($3,752,561).[16] In short the payment of $1 by the wage-worker for commercial health insurance will provide him with only 25 cents to 50 cents in benefits in time of sickness.

Moreover, a thorough investigation of industrial health and accident insurance through commercial companies, made a few years ago by various state insurance commissioners, showed that many of the companies had an entire disregard for the interests of the insured and that some were guilty of downright frauds in the settlement of claims.[17] The report of the Utah insurance commissioner for 1915 indicates that the investigation did not entirely put an end to such unscrupulous methods. The commmissioner states that "the limitations and restrictions in some of these accident and health policies are such that it is doubtful if anyone could recover on them," which results in frequent complaints to his department by dissatisfied policy-holders.[18]

Another drawback to commercial health insurance consists of the administrative difficulties inevitable under any such system. The provision of medical care—one of the first essentials of health insurance being to prevent and to cure diseases—is extremely hard if not impossible if a few members live in one village, a larger group in a second town, many members in a city, and isolated members on farms. To see that each person has access to a doctor involves contracts with many physicians and often no choice of doctor by the patient. Then, too, a scattered membership makes it difficult to check malingering, since many communities do not have a sufficient

[16] *Insurance Year Book*, 1915, p. A-388.

[17] The results of the investigation are to be found in the *Proceedings of the National Convention of Insurance Commissioners*, 1911, Vol. II.

[18] Salt Lake (Utah) *Republican*, June 25, 1916.

"It is a simple economic proposition for the community to aid workmen with small incomes to provide adequate insurance against loss due to sickness. Changing conditions in the United States will sooner or later, as in other countries, force the enactment of a law providing for sickness."
—B. S. Warren, Surgeon, U. S. Public Health Service. Sanitary Adviser, U. S. Commission on Industrial Relations.

number of members to justify the appointment of a paid sick visitor.

The administrative difficulties in handling health insurance through commercial channels have been recognized by no less an authority than the late John F. Dryden, for many years president of the Prudential Insurance Company. This company originally planned to provide relief in sickness and accidents as well as payments on the death of both adults and infants. But "Subsequent experience proved," says Mr. Dryden, "that under present conditions the operations of an industrial company must of necessity be limited to the assurance of a certain sum payable at death."[19]

The experience of the large British industrial insurance companies in administering health insurance under the British national insurance act illustrates the disadvantages of providing health insurance for the wage-worker by means of commercial insurance companies. Any improvements were not due to the companies but to the compulsory nature of the system. However, the administrative difficulties involved in organizing medical aid and sick visiting were still present. In Great Britain medical benefit under the national insurance act is not administered by the insurance carrier, but through separate bodies, organized according to locality. Thus the necessity of organizing medical aid by local groups was recognized most emphatically, even though its separation from the insurance carrier is responsible for many of the weaknesses in the British system.

Moreover, sick visiting under the British act has been extremely difficult because of the scattered membership. It is only a mammoth company such as the British Prudential, or one with a centralized membership, which has been able to develop any effective sick control. Even the Prudential after about a year's experience in paying benefit had only just begun to organize a system of sick visiting in an effort to see whether a comprehensive system for all its members scattered throughout the country would pay.[20] This cautious procedure, not-

[19] John F. Dryden, *Addresses and Papers on Life Insurance and Other Subjects*, 1909, pp. 31, 32.

[20] Great Britain, *Report of the Departmental Committee on Sickness Benefit Claims*, Appendix, Vol. I, p. 144. (Cd. 7688 of 1914.)

"This measure, from a humanitarian standpoint, is one that should receive the support of every man, to relieve the distress of those that produce the nation's wealth."—S. E. Heberling, President, Switchmen's Union of North America.

withstanding the widespread belief that efficient sick visiting is the only check upon unnecessary claims,[21] shows the difficulties and the cost involved in sick control of a widely distributed membership, inevitable under commercial health insurance.

4. Fraternal Insurance Cannot Meet These Needs.

The appeal of American fraternal orders is not wide enough to enable them to afford the protection against sickness universally needed among wage-earners.[22] While the proportion of wage-earners is probably fairly high in the Catholic and immigrant orders, a large part of fraternal membership has always been composed of business and professional men.[23] Among the workingmen the more highly paid skilled mechanics are represented rather than the rank and file. It is a well-known fact that the fraternal orders like the Odd Fellows and Masons which have no real insurance systems, but which pay some benefits in times of sickness, have a middle-class rather than a working-class membership.

In estimating the extent of the protection afforded the working-people of the United States in time of sickness by fraternal societies, a further limitation must be considered. This is the high lapse rate. In 1915 the combined societies of the United States and Canada wrote 960,735 new certificates, yet their net increase in membership for the year was only 139,099.[24] Six-sevenths as many members left as joined the societies. Similar figures for other years show that the shifting membership is a constant problem to fraternal

[21] Great Britain, *Report of the Departmental Committee on Sickness Benefit Claims*, p. 27. (Cd. 7687 of 1914.)

[22] See p. 184.

[23] The most important single investigation of American fraternal societies was published by the Connecticut Bureau of Labor Statistics in 1891. According to this investigation 26 per cent of the membership of fraternal societies with branches was made up of business and professional men, 38 per cent of "well-paid mechanics" and 31 per cent of "low-paid mechanics and clerks." In "societies without branches," 54 per cent were business and professional men and only 17 per cent "low-paid mechanics and clerks."

[24] *Statistics of Fraternal Societies*, 1915, pp. 202-204.

"We are every day coming nearer the time when in this country we shall see laws enacted to provide, by some state insurance scheme, medical care for the poor."—Arthur Dean Bevan, M.D., Chairman, Council on Medical Education, American Medical Association.

societies and that it shows no signs of decreasing. Thus in 1909 as many as 1,051,609 new certificates were written, but the net increase in membership was only 327,338.[25]

Fraternal society benefits generally include medical care as well as a weekly cash benefit. Neither of these seems to be adequate. According to the plan usually followed each "lodge" or local branch of a society employs a doctor whom its members pay at the rate of $1 a year. At this rate, which has become widely fixed by custom, it is charged that the members do not receive proper attention nor the physician adequate pay. Consequently such practice is largely in the hands of inexperienced or second-rate doctors, until "lodge" or "contract" practice has become a by-word among the profession.[26]

The low level of the cash benefits is apparent when it is considered that in the societies offering any form of health insurance the average payment per member for both sickness and accident claims was only $1.34 in the year 1914 and $1.07 in 1909. The well-known sick fund of Leipzig, Germany, under, it must be remembered, a much lower wage-scale than the American, expended an average of $4.91 per member for cash benefits alone in 1913.[27]

In sickness prevention activity by fraternal societies is almost entirely lacking. They have no opportunities for work in the field of industrial hygiene and they have taken up questions of personal hygiene only to a very slight extent. In an investigation of fraternal society health insurance in New York City in 1914 it was found that only two out of fourteen societies carried on preventive work, and that these confined their activities to printing occasional articles on health subjects and to arranging a few lectures on tuberculosis.[28] On any large scale preventive work is untouched by

[25] *Ibid.*, 1910, p. 204-222.

[26] See "Health Insurance," *New York State Journal of Medicine*, February, 1916, p. 89.

[27] *Report of the General Sick Fund of the City of Leipzig*, 1913, pp. 74-75.

[28] See p. 153.

"It is my hope that the various state legislatures and the Congress of the United States will take this question up immediately and settle it in a manner that will protect the workmen and those dependent upon them while incapacitated because of sickness."—Van Bittner, President, District No. 5, United Mine Workers of America.

fraternal societies, with scant signs of any growth of interest in the matter.

Furthermore the exceptional workman who may carry health insurance in a fraternal society cannot be sure that he has any lasting protection. The problem of "reorganization" to avoid bankruptcy and disintegration has become a leading question with fraternal societies. Their financial difficulties arise from their frequent failure to charge sufficient rates for life insurance.[29] Health insurance as well as life insurance protection is swept away in these catastrophes. Professor Henderson thus describes the situation:

> The premiums of the older members are in comparison with those of younger members relatively too low to cover the risk and therefore the younger members must carry more than their share of the burden. Ordinarily the fraternals have declined to provide reserve funds or have very inadequate reserves, and so the benefits must be paid out of assessments levied at or near the time of ripened claims. In consequence of these defects the rates of assessments rise gradually, and therefore the younger members, who must carry more than their proper share of the cost, fall away from membership, only older members remain; the burden becomes unbearable, and the brotherhood becomes bankrupt, unable to fulfill its promises or at least the expectations of the members.[30]

The matter of adequate rates was taken up as long ago as 1906 by the National Fraternal Council, but even the rates which it suggested, based as they were on considerably more favorable calculations than the tables used by commercial insurance companies, had been adopted in 1909 by only nineteen out of 114 societies. "Readjustments" were still going on in 1915 and "disasters" during the year included "the receivership of the Knights of Honor and of some of the state grand lodges of the Ancient Order of United

[29] It should be noted that some fraternal societies do not come under the supervision of state insurance departments. Out of fourteen fraternal societies studied in New York by the American Association for Labor Legislation in 1914, eight of the smaller ones were not under any form of state regulation.

[30] Charles R. Henderson, *Industrial Insurance in the United States,* 1909, p. 116.

"Labor representatives and organizations will lend every aid to such a campaign, understanding best of all, because of individual and collective experience, the economic loss to the nation because of sickness."—Union Labor Bulletin, (Newark, N. J.), September 4, 1914.

Workmen."[31] The need of state regulation to put fraternal insurance on a thoroughly sound basis is now admitted by the leaders of the movement.

5. Trade Union Benefits Cannot Meet These Needs.

Mention has already been made of the small number of workers covered by trade union sick benefit funds. Under present conditions any large increase in the numbers so covered appears unlikely. The main efforts of American unionism are now being directed toward the organization of the unskilled, low wage trades. Workers in such lines cannot afford the high dues necessary to cover even the present low scale of benefits. Nor are all trade unionists in favor of having benefit funds. Many union men believe that these funds are a handicap rather than a help to organized labor in its efforts for better working conditions. Mr. Charles H. Moyer, president of the Western Federation of Miners, has lately said:

> The constitution of our international defines its objects to be the maintenance of the rights of the workers to increase the wages and improve the condition of employment of our members by legislation, conciliation, joint agreements or strikes. This, in fact, should be the sole aim and purpose of labor unions, and yet many of our locals practically lose track of these primary objects and permit themselves to become purely sick and death-benefit associations. One of the principal causes for the failure of many locals can be traced direct to its inability to meet these benefits or the excessive taxation required to meet the same.[32]

It is also doubtful whether even in their limited field trade union sick benefits entirely fill the needs of members in time of sickness. With rare exceptions no medical care is provided. In 1908 in fifteen out of nineteen international unions the weekly cash benefit which must cover both medical care and living expenses was $5 or less, and in only two cases was this sum payable for more than thirteen

[31] George Dyre Eldridge, "Fraternal Insurance in 1915," *Fraternal Monitor*, February 1916, p. 22.

[32] Charles Moyer, *The Miners' Magazine*, February 3, 1916.

"It (health insurance) is a measure which should receive the support and advocacy of every wage-earner. . . . It is a beginning which will lead to wider measures of public health conservation."—New York Call, March 14, 1916.

weeks a year.[33] Local funds were similarly limited, the prevailing rate being $5 a week or less, and two-thirds of the whole number paying no benefits for longer than thirteen weeks in any one year.[34] Over half of the local funds did not pay benefit for the first week of sickness or for illnesses lasting less than a week.

Nor does it seem possible for the trade unions alone, without active cooperation from employers, to do widely effective work in the prevention of disease. An investigation of sickness benefit funds in New York City in 1914 showed that of eleven unions paying sickness benefits, only two had organized any preventive work.[35] In one the shop chairmen were supposed to report unsanitary conditions to a general sanitary committee which would take them up with the state labor department. The other union, composed of garment workers, came under the well-known Joint Board of Sanitary Control, which was able to do important work in improving shop conditions primarily because it represented both employers and employees.

6. Voluntary Subsidized Insurance Cannot Meet These Needs.

Certain European countries encourage health insurance among workingmen by subsidizing societies formed for that purpose. This system is of importance in the five European countries of Belgium, Denmark, France, Sweden, and Switzerland. In Belgium and France the help given in this way is rather limited and incidental, but in Denmark, Sweden, and Switzerland—all of which, it should be noted, are small countries, whose people are imbued with the cooperative spirit—governmental subsidies exist on a fairly comprehensive scale.

Though the subsidy system undoubtedly stimulates the growth of health insurance, the rate of increase is comparatively slow, leaving

[33] *Twenty-third Annual Report of the United States Commissioner of Labor*, 1908, p. 42-47.

[34] *Ibid.*, pp. 234-254, 264-266.

[35] See p. 153.

"Our former insistence upon the competence of voluntary action to deal with accidents and disease in which the factor of the inherent risks of the industry is so great is being displaced by a belief in the necessity for compulsory insurance administered by governmental authority."—James M. Lynch, former President, International Typographical Union; member, New York State Industrial Commission.

a large number of wage-workers without protection. As a standard for comparison it seems fair to take the compulsory health insurance systems of Germany and Great Britain, both of which cover about 30 per cent of the total population and nearly 50 per cent of the male population.[36]

No subsidized voluntary system is equally inclusive. In France, a land noted for its thrift, the "approved" (subsidized) societies were estimated to include in 1907 4,091,000 persons or nearly a tenth of the total population. But of this number 665,000 were school children and 475,000 were "honorary members," well-to-do and benevolent persons who join the societies from philanthropic motives, leaving only 2,951,000 adult wage-working members. Of Belgium Frankel and Dawson state that "in 1907, there were 3,330 associations with a membership of 400,000. When it is considered that Belgium has a population of 7,300,000 of whom about 1,200,000 are wage-earners, it is clear that a large number of workingmen are still unprovided for."[37] According to an investigation made for the French government it has taken sixty-five years to attain this growth which has been reached only after continuous efforts to stimulate competition between the societies, to offer special privileges to the directors, and to increase membership through special propaganda committees.[38]

Nor have the countries with really comprehensive subsidy systems succeeded in solving the problem of numbers. The Swiss subsidized societies have a membership of somewhat over 400,000 out of a total population of nearly 4,000,000.[39] In Sweden in 1910 after nearly twenty years of subsidy-granting there were 500,000 persons, or not quite 10 per cent of the population, insured in registered funds.[40]

[36] I. M. Rubinow, *Standards fo Health Insurance*, 1916, p. 22.

[37] Frankel and Dawson, *Workingmen's Insurance in Europe*, p. 200.

[38] Joseph Bégasse, *Les Assurances Sociales en Belgique*, 1907, pp. 5, 8.

[39] Harold G. Villard, "Switzerland's Plan of Introducing Workmen's Health and Accident Compensation," *The Economic World*, Dec., 1915, p. 826.

[40] Arbetsstatistik B:10. *Registrerade Sjukkassors Verksamhet*, Aar 1910, pp. 5, 9, 27.

"We feel it is perhaps the most important piece of social legislation, aside from the passage of the present workmen's compensation law, which has been proposed in New York State in the last decade."—Lester F. Scott, Assistant Director, The People's Institute.

Meanwhile the state subsidy increased more than twice as fast as the membership. Denmark, with 23 per cent of its total population insured against sickness in voluntary subsidized societies, is sometimes cited as an example of the adequacy of voluntary methods. But as I. M. Rubinow points out, "These figures are very deceptive, however. Of the total number insured, women constitute somewhat more than the majority, because married women may insure under the law, so that the number of families actually protected is only about one-half, and the proportion of insured males not over 25 per cent."[41]

Moreover, judging by the rate of benefits paid, governmental assistance alone is not sufficient to enable the societies to meet the real needs of the wage-worker in time of sickness. Thus in both France and Switzerland somewhat over half the societies failed to grant both medical and cash benefits.[42] The Danish societies are required to give both medical and cash benefits in order to receive a subsidy, but over half the societies do not pay for ordinary drugs and medicines and only 18 per cent pay the entire cost.[43] The rate of cash benefits is low and the term for which they are payable is generally short. In Denmark nearly 60 per cent of all the societies discontinue the payment of benefits at the end of thirteen weeks and in Sweden almost half the societies have a limit of less than that length.[44] Daily benefit in Denmark was 11 to 13 cents in over half the societies and rose as high as 26 cents in only one-eighth of them. In France in 1905 the average sick benefit a day was about 25 cents.[45] This may be contrasted with the average daily cash benefit of the Leipzig sickness insurance fund, which, fixed at 55 per cent of wages, was 42 cents a day.[46] Cash benefits under the English law are 41 cents for men and 29 cents for women.

[41] I. M. Rubinow, "Standards of Sickness Insurance," *Journal of Political Economy*, March 1915, p. 231.

[42] Frankel and Dawson, *loc. cit.*, pp. 208, 220.

[43] I. G. Gibbon, *Medical Benefit in Germany and Denmark*, p. 153.

[44] I. M. Rubinow, *Social Insurance*, p. 246.

[45] *Twenty-fourth Annual Report of the United States Commissioner of Labor*, 1909, Vol. I, p. 822.

[46] *Report of the General Sick Fund of the City of Leipzig*, 1913, Tables III and IX.

"We strongly urge the voters of this country to.....endeavor to commit every candidate, according to the office he seeks, to support .....social insurance against sickness and accidents."—Washington Conference on Real Preparedness, June, 1916.

Yet, like the unregulated American "fraternals," in some cases the subsidized societies have gotten into difficulties through making higher payments than they could really afford. Frankel and Dawson say of the Danish societies:

> Practically all are insolvent from an actuarial standpoint with insufficient funds accumulated to meet their claims permanently. This has already shown itself by the fact that several societies have suspended. [A plan for federation has been worked out but] newer and larger societies holding aloof from this federation are offering much lower rates, and are thus rendering the readjustment and conservation of older societies more difficult and precarious.[47]

Of the Belgian system also the director of the General Savings and Retirement Fund reported at the Third International Congress of Actuaries held at Paris in 1900, "In general, the mutual sick-benefit societies do not fulfil the necessary requirements of a safe and rational organization, their bases are entirely empirical."[48] Swedish societies are also pronounced unsound by experts "and unless they readjust [their rates] upon an adequate basis for a voluntary system, or insurance is made obligatory, many of them must fail."[49]

In preventive work, voluntary subsidized societies are necessarily at a disadvantage because they cannot enter the field of industrial hygiene. Notably in France certain societies have recently become active in combating the personal aspects of disease, maintaining sanatoria for tubercular members and printing and distributing literature on personal hygiene.[50] But in the absence of any possible control over the working conditions of their members much preventable disease must remain unchecked.

However, by far the most significant count against voluntary subsidized insurance systems is the trend toward compulsion in the countries having such systems. Frankel and Dawson say of the situation in France, "Of all the trade groups, the best protected against

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[47] Frankel and Dawson, *loc. cit.*, p. 190.

[48] *Twenty-fourth Annual Report of the United States Commissioner of Labor*, 1909, Vol. I, p. 489.

[49] Frankel and Dawson, *loc. cit.*, p. 189.

[50] Frankel and Dawson, *loc. cit.*, p. 213.

"The health insurance measure has passed the stage of discussion and become a live issue all over the United States."—Dayton (Ohio) Journal, May 17, 1916.

sickness are seamen and miners; for them obligatory sickness insurance schemes have been established by law to which both employers and employees contribute."[51] The Swiss health insurance act, though voluntary, may be made compulsory by any canton so desiring, and under its terms up to 1914 three of the Swiss cantons had decided to introduce compulsion.[52]

As a result of dissatisfaction with the voluntary system the Chamber of Representatives of Belgium in May 1914 (just before the outbreak of war) passed a bill for compulsory health, invalidity, and old age insurance which would have been referred to the Senate in November, 1914[53] had not all Belgian legislation been stopped by the war. The special committee of the Chamber of Representatives appointed to study this bill for compulsory insurance stated in its report, "It can be said that Belgium had tried by all means to turn the people toward saving and economy; before compulsion was introduced, education for the encouragement of initiative was tried."[54] The Swedish government has discussed a project for compulsory maternity insurance for all women between the ages of fifteen and fifty-one.[55] Even in Denmark, where voluntary subsidized insurance has reached its widest development, the compulsory principle has been introduced in a law of August, 1908, which requires employers to insure alien seasonal workers against sickness.[56]

[51] Frankel and Dawson, *loc. cit.*, p. 211.

[52] Office Suisse des assurances sociales, *Rapport du Department Suisse du Commerce, de l'Industrie et de l'Agriculture sur Sa Gestion en 1914*, III Division, pp. 13-15.

[53] Chambre des Representants, *Annales Parlementaires*, p. 2031.

[54] *Bulletin Comite Central Industriel de Belgique*, Brussels, April, 1914, p. 218.

[55] Victor von Borosini, "What European Nations Are Doing in Maternity Insurance," *The Survey*, March 14, 1914, p. 745.

[56] I. G. Gibbon, *loc. cit.*, p. 14.

"Insurance against sickness is proposed as a natural development of the principle of workmen's compensation..... This principle is as plain as day and California voters, unless they undergo a strange transformation in the next year or two, will stand in overwhelmig numbers behind it."—San Francisco Bulletin, February 24, 1916.

VI. COMPULSORY CONTRIBUTORY HEALTH INSURANCE PROVIDING MEDICAL AND CASH BENEFITS IS AN APPROPRIATE METHOD OF SECURING THE RESULTS DESIRED.

The desired results of more adequate treatment, financial protection, and prevention of illness, which existing agencies are unable to secure, can appropriately be reached through a comprehensive system of compulsory health insurance, providing medical care and cash benefits, and maintained, under democratic management, by joint contributions from employers, employees, and the state.

1. Compulsory Insurance Presents Advantages Not Offered by Any Other Method.

Under a compulsory system a number of important financial and administrative insurance problems are solved with an efficiency impossible under any other method.

(1) *This Method Makes Certain the Insurance of All Wage-Earners Who May Reasonably Be Expected to Require Protection.*

The difficulty of insuring under a voluntary scheme those who most require protection in time of illness is not peculiar to this country. In Great Britain, where voluntary health insurance through the fraternals and the trade unions had reached an exceptional development, it is estimated that 5,500,000 wage-earners were insured against sickness. Even this generous measure of protection did not, however, suffice, and it was necessary to resort to compulsion. The compulsory measure passed in 1911 included a total of 13,742,000 wage-

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A governmental system of sickness insurance is preferable because: More democratic; the benefits would be regarded as rights, not charity. Compulsory features, obnoxious under private insurance, would be no longer objectionable. . . . European experience has proved the superiority of government systems to private insurance."—Final Report, U. S. Commission on Industrial Relations; signed, among others, by John B. Lennon, Treasurer, American Federation of Labor; James O'Connell, Second Vice-President, American Federation of Labor; Austin B. Garretson, President, Order of Railroad Conductors.

earners over sixteen, or more than twice as many as had been insured under the voluntary system. With a few exceptions it covers all manual workers and all other employed persons over sixteen and under seventy years of age earning less than $768 a year. The compulsory systems of other countries also embrace large groups. The German act, for instance, includes workmen, helpers, journeymen, apprentices, servants and sailors, and applies to foremen, officials, clerks, musicians, actors, teachers, and tutors earning less than $600 a year, a total of 19,000,000 workers, or about 30 per cent of the population.

Equally inclusive was the bill for compulsory insurance presented to the legislatures of Massachusetts, New York, and New Jersey in 1916 by the American Association for Labor Legislation. This bill included, with certain exceptions, every person employed in the state at manual labor and all other employed persons earning less than $100 a month. For the wage-earner's family, whose illness ordinarily entails no financial loss save that involved in physicians' bills, medical care during illness is provided in the Standard Bill and should be incorporated in bills presented to the legislature wherever practicable.

(2) *Compulsory Health Insurance Renders the Expensive Reserve Fund of Voluntary Insurance Unnecessary.*

A reserve fund, set aside to meet future claims, is an essential in voluntary insurance where there is no certainty that there will be a continuous accession of young lives. If no such accession is secured, and if the society has failed to lay aside a sufficient reserve, it finds itself burdened by the increasing claims of its members as they advance in age. It is then compelled to raise the contribution. This high rate, however, fails to attract young members, so that the society may eventually be forced into insolvency and fail to meet its obligations.

Compulsory insurance, with a definite guarantee that each carrier will have its share of the young men and women just

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"Health insurance is one of the biggest factors in the efficiency of the leading commercial nations, everywhere. There is hardly one industrial nation, outside of the United States, that does not rank it as one of the chief factors in its industrial progress, and that for well proven reasons."—Boston Daily Advertiser, March 1, 1916.

coming into insurance, presents a very different situation. Here the reserve is unnecessary, since the constant influx of young lives will counterbalance those growing older. Just as in voluntary insurance, the overpayments of each insured person in youth will counterbalance his underpayments in old age, but instead of building up his own individual reserve they will be used to cover the underpayments of some older man, while his own underpayments in old age will in turn be covered by the overpayments of some younger man. Under such a system it is necessary to carry only a small reserve to provide for an epidemic or other unusual occurrence, such as the German requirement of a reserve equal to one year's expenditure.

This is the method that has been adopted in the proposed plan of the American Association for Labor Legislation which provides for a small reserve, in this instance equal to one-sixth of the total expenditures for the preceding three years.

(3) *Compulsory Health Insurance Offers an Opportunity for Simplified and Economical Administration.*

The high administrative cost necessary to the acquisition of business and to collection of contributions under industrial insurance can be reduced to a minimum in compulsory insurance. Under compulsion all the tedious work of persuading a man that he needs insurance is accomplished by law. Even in Great Britain where each insured workman has the right to join any one of many thousands of approved societies, resulting in widely scattered membership and unnecessarily high administrative costs, the total chargeable to this account amounts to only 14 per cent of the income of the national health insurance fund.[1] In contrast to this, the societies which collect contributions for burial benefits spend for administration 37 per cent of their income according to one estimate,[2] or 48

[1] Hon. Charles Roberts in House of Commons, July 14, 1915; reported in *National Insurance Gazette*, July 24, 1915.

[2] *Reports of the Chief Registrar of Friendly Societies* for the year ending December 31, 1912, House of Commons paper 121 of 1914, p. 49.

"Nearly a dozen European countries have divided the cost of sick benefit and medical care for the worker between the state, the employer, and the worker on an insurance principle, while the government of this country still leaves the sick worker to sink or swim, as best he can."—Beaver Falls (Pa.) Tribune, December 15, 1915.

per cent according to an official statement.[3] Further economies in management can, however, be effected under a better system of administration, such as that in operation in Germany, and that advocated for this country in the model bill. This plan differs from the British in prescribing the carrier, within certain limits. It allows each wage-earner to substitute membership in an "approved" fraternal society, a trade union fund, or an establishment fund for insurance in the ordinary carriers,—the local fund of the district or the trade fund which may be formed in a locality where large numbers are engaged in one industry. If these options are not exercised, a worker is automatically insured in the trade fund formed for the trade at which he is employed or in the local fund for the district in which he lives. Such a plan practically abolishes competition between societies and simplifies the administration because of the concentration of members. Moreover, the mutual control of these funds by employers and their insured employees will make for economy in administration, since the influence of both parties as contributors will tend to prevent extravagance and fraud, while the influence of employees as beneficiaries will prevent any undue decrease in benefits. The experience of the Leipzig sick fund shows that its expense in local administration, as distinguished from the total cost which includes the expense of central administration, is less than 10 per cent of the total expenditure, varying from a minimum of 7.4 per cent to a maximum of 9.4 per cent.[4] The average amount devoted to local management expenses in all the German sick funds is still less; in 1902 it reached its maximum level of 5.1 per cent of total expenditures;[5] by 1912 it had been reduced to its minimum level of 4.5 per cent.[6]

[3] *Ibid.* for year ending December 31, 1913, House of Commons paper 121 of 1915, p. 20.

[4] *Report of the General Sick Fund of the City of Leipzig,* 1913.

[5] *Statistik des deutschen Reichs,* Vol. 156, "Die Krankenversicherung im Jahre 1902," p. 38*.

[6] *Ibid.,* Vol. 268, "Die Krankenversicherung im Jahre 1912," p. 15*.

"If some scheme can be worked out for the United States to establish a system of health insurance similar to that now in effect in certain European countries, I am sure it will be of great benefit to the people of this country."—H. M. Bracken, M.D., Minnesota State Board of Health.

The localization of membership possible when the insurance carrier is prescribed also simplifies the administration of medical care. Reference has been made to the difficulties which industrial insurance would encounter, if medical care for a widely distributed membership were attempted. The British effort to solve the problem by placing medical care under the jurisdiction of a local committee totally distinct from the insurance carrier has many weaknesses. Under this system the doctor is divorced from any responsibility for the funds of the insurance carrier upon which he virtually writes a check each time he issues a certificate of incapacity for work, and he is therefore tempted to be unduly generous.[7] The carriers, on the other hand, have no effective control over the physicians responsible for the medical treatment of their members and are able to make complaints against even flagrant abuses effective only through a most indirect procedure. This experience reveals the necessity for the administration of medical aid through the carrier, in conformity with the recognized principle of local organization. If this is to be accomplished, the membership must be centralized, and to secure concentration of membership the carrier must be prescribed.

2. The Proposed Method Supplies All the Needs of the Sick Wage-Earner.

By its provision for adequate medical attention, cash benefits equivalent to two-thirds of wages, maternity benefits and funeral benefits, the proposed method meets all essential needs of the wage-earner during a period of illness.

(1) *All Necessary Medical Care Will Be Provided for the Wage-Earner, Including Medical, Surgical, and Nursing Attendance, Hospital Care, and Necessary Drugs and Prescribed Appliances up to the Value of $50 in Any One Year.*

The medical care which is made a matter of legal right by the proposed plan of health insurance is far above that enjoyed at the existing time by the wage-earner, who is compelled too often to

[7] Departmental Committee on Sickness Benefit Claims (Cd. 7687 of 1914), p. 36.

"The plan is full of splendid possibilities of higher standards of medical and nursing care, especially among the poor and those of moderate incomes."—New York City Trained Nurse, February, 1916.

accept charity or to forego the expert medical aid required. The family of the insured, also, will be provided with requisite medical aid, which will at least greatly reduce and probably eliminate entirely the expenditure for doctors' bills on an individualistic basis and assure medical advice when there is need for it.

Moreover, the legal claim to necessary medical care will stimulate backward communities to make the arrangements which they have thus far failed to make. For instance, the insured wage-earners of Dutchess County, N. Y., where nearly one-quarter of those ill during 1912 received no medical aid and where the necessary nursing and medical facilities were often not available, would have demanded the requisite services if they had been legally entitled to them. Under health insurance the provision of proper medical aid to hasten recovery will be a matter of financial importance to the funds, eager to cut down unnecessary expense. To facilitate such provision the insurance funds are empowered, with the consent of the state supervisory commission, to erect and to maintain hospitals where necessary. In view of the large numbers who will be provided for on the same basis, a more systematic organization of medical aid will also be possible. In this connection Michael M. Davis, Jr., of the Boston Dispensary says, "If a system of sickness insurance is to provide medical service for a large part of the working population on the financial basis provided by insurance payments, surely the medical organization of the system ought to be in line with the most advanced forms of medical work; or at least the system should contemplate development in that direction."

That development of medical care is not an idle hope is shown by experience abroad. In Great Britain, for instance, a redistribution of doctors to meet the needs of the industrial population had begun within two years after the enactment of the health insurance law. The law has also stimulated provisions for the care of tuberculosis. Under its influence have occurred the "appoint-

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"Germany has demonstrated that sickness and old age pensions increase, rather than diminish, a people's prosperity. During the period that she has enjoyed the pensions system she has been able to sell her merchandise throughout the world in competition with other countries. Her success has been such that England was forced to follow her, and has adopted a complete system of social insurance; and France is far advanced towards that end."—Boston Record, October, 1915.

ment of 150 'tuberculosis officers' and the opening of about as many public 'tuberculosis dispensaries'; the hasty adoption or extension of about 250 existing institutions to serve, more or less adequately, as 'sanatoria,' . . . whilst a score or so of new buildings, planned for some 3,000 beds, are in various stages of progress."[8] In addition, 1,200 shelters[9] have been placed at the disposal of the insured tubercular patients to enable them to sleep out-of-doors while living at home.

In Germany, where health insurance has been in effect since 1884, development has been more marked. Before the adoption of the insurance laws there was approximately one hospital bed for every 800 persons in the empire; in 1911 there was one bed to every 322 persons. "There can be no doubt," states an unprejudiced authority, "that the extensive development in hospital construction, management and improvement generally is directly due to the insurance against accident, sickness and invalidity."[10] Along with growth of hospitals has gone a growth of medical knowledge concerning the diseases which closely concern the people. Says a German observer: "The experience with social insurance has led to new knowledge in the field of occupational diseases, epidemics, and the care of victims of accidents. In the hospitals and similar institutions of the insurance carriers the physicians find the opportunity for further study of curative methods."[11]

In country districts where doctors are few and far between, the beginnings of sickness were often ignored until too late. A connecting link between medical man and patient has been provided in the "rural health stations," where medicine chests and obstetrical supplies are kept in charge of a nurse. The nurse cooperates with physi-

[8] Fabian report on "The Working of the Insurance Act", supplement to the *New Statesman*, March 14, 1914, p. 22.

[9] *Report for 1913-14 on Administration of National Health Insurance*, [Cd. 7496 of 1914.] p. 484.

[10] *The Hospital*, London, June 24, July 1, 1911.

[11] *Soziale Kultur und Volkswohlfart während der ersten 25 Regierungsjahre des Kaisers Wilhelm II, 1913, p. 178.*

"Hundreds of thousands, now fighting on the field of battle for the fatherland, may trace their health and capacity to the timely and proper treatment received with the aid of sickness insurance."—Bulletin of the American Chamber of Commerce in Berlin, December, 1915.

cians, sick funds, and others, informs the insurance carriers of the patients' condition, suggests necessary measures, and watches the insured after recovery. The sick funds also grant convalescent care in special homes, and special unions have been formed in some parts of the country for the care of convalescents. Indeed, as W. H. Dawson has well said:

> It is only necessary to mention the dispensaries for consumptives, the dispensaries and clinics for infants, the first aid societies, the school doctors, the day nurseries and care rooms for children, the holiday colonies and forest resorts, the people's kitchens, the milk depots, and the various societies and agencies for combatting alcoholism and even more insidious diseases, as examples of a new and large order of hygienic endeavors which play a part of the utmost importance in the life of the German working classes. Many of these institutions directly owe their existence to the impetus given by the insurance laws, and all of them are carried on, more or less consciously, as part of the national health crusade for which the insurance system is the rallying ground.[12]

That in spite of sharp disagreement at first the development of medical care under health insurance has proceeded without injury to the medical profession is shown by numerous reports both in Germany and in England. Early in 1914, before the war, a German physicians' organ stated that many new contracts had been signed between doctors and insurance societies, and that "for the present, at all events, the differences between the contracting parties have been brought to an end."[13] "The medical profession in Germany," declared another authoritative publication, "has never been really opposed to the principle of national insurance, partly because it recognized that the system was doing an immeasurable amount of good, and partly because the members . . . believed that a service on healthy, prosperous, and honorable lines would be developed through the influence [they] could exert on the authorities."[14] In Great

[12] William Harbutt Dawson, *Social Insurance in Germany*, pp. 206-207.
[13] *Münchener Medizinische Wochenschrift*, January 14, 1914.
[14] *British Medical Journal*, March 7, 1914, p. 547.

"As a natural result of health insurance, all concerned, including the worker himself, would be impelled to take a greater interest in the maintenance of health. . . . Health insurance is one step toward the control and ultimate eradication of these expensive drains on the strength and resources of humanity."—Detroit (Mich.) Tribune, Jan. 30, 1916.

Britain, also, "After the bitterness of two years ago . . . throughout the country generally there was growing up a desire on the part of the panel practitioners to work the act in a spirit of friendly co-operation with the insurance authorities."[15] "The individual animosity and antagonism to the insurance act among physicians," says Dr. Alexander Lambert, "has practically subsided."[16]

(2) *A Cash Benefit Equal to Two-Thirds of Wages Will Relieve Financial Stress During the Illness of the Bread Winner.*

The absence of income entailed by illness of the breadwinner often compels a family to lower its standard of living, run into debt, or apply for charitable assistance. That two-thirds of wages will be sufficient, and yet no more than adequate, to protect a family during illness from a breakdown of its standards is indicated in the American studies of wage earners' budgets. According to the study made by Robert C. Chapin for the Russell Sage Foundation, the expenditure on food, rent, heat, and light decreases from three-quarters of the total annual income in families with incomes of $400-$800, to a little more than two-thirds of income in families possessing an income of $800-$1,200.[17] A similar proportional outlay for the bare necessaries of life is shown in the much larger study made in 1901 by the United States Commissioner of Labor in the principal industrial centers of thirty-three states. In this inquiry covering 10,751 "normal" families with an annual income of $300 to $1,200, those in the $400-$800 group devoted a little more than two-thirds of their expenditure to these four items; those in the $800-$1,200 group spent slightly less than two-thirds for food, rent, heat, and light. The margin for savings was so slight as to make total expenditure nearly equal to the annual income.[18]

[15] *Ibid,* April 17, 1915, p. 689.

[16] Report to the house of delegates of the American Medical Association, 1916, by Alexander Lambert, chairman of the Committee on Social Insurance, p. 128.

[17] Robert C. Chapin, *loc. cit.,* p. 70.

[18] *Eighteenth Annual Report of the United States Commissioner of Labor,* 1903, "Cost of Living and Retail Prices of Food," pp. 585, 367, 368.

"Within a few years health insurance will be as widespread as compensation. . . . There is a greater need for a "Health First" campaign than for the "Safety First" movement."—Johnstown (Pa.) Tribune, March 17, 1916.

These figures indicate that a weekly cash benefit equal to two-thirds of wages during the breadwinner's illness will keep the wolf from the door and will keep the family from the door of the relief agency. On the other hand, they show conclusively that strict economy in the purchase of clothing and of miscellaneous items must be exercised. Such privation, while not serious, offers a direct financial incentive to return to work as soon as possible, an incentive which would be absent if full wages were paid during illness. The figures also demonstrate a second fact of equal importance, namely, that a weekly benefit of less than two-thirds of wages would be inadequate to meet the necessary running expenses of the family, and that on a smaller amount the family must draw on savings, run behind on the rent, obtain credit from the grocer, borrow, seek an income from lodgers or from the employment of wife or young children, or, as a last resort, ask charitable aid. Such an inadequate scale of benefit, although an improvement over present conditions, would only perpetuate the present system of under-feeding, lowered standard of living, and alms seeking which are the undesirable attendants upon the sickness of the breadwinner.

If any further justification of the standard benefit of two-thirds of wages were needed, it is found in the precedent established by Massachusetts, New York, and Ohio in requiring a payment of two-thirds of wages during disability resulting from industrial accident. Approximately the same standard is maintained in California, Kentucky and Wisconsin, which require a payment of 65 per cent of wages, while Hawaii and Texas provide 60 per cent.[19] The standard proposed for health insurance follows that already established in a similar field by the progressive states of the country.

(3) *The Maternity Benefit Provided for the Wives of Insured Workmen and for Insured Women Will Supply a Pressing Need.*

The need for better obstetrical aid than is provided to-day by the majority of midwives who attend 40 per cent of the births in this

[19] American Association for Labor Legislation, *Standards for Workmen's Compensation Laws*, p. 4.

"The movement for health insurance—the second large step in a comprehensive system of social forethought—is fairly under way in America."—New Republic, March 11, 1916.

country is evident. Through a health insurance system such as that embodied in the model bill, which provides an obstetrician for the wives of its members, as well as for insured women, it will be possible to supervise the character of the services rendered to those who to-day can be tempted to engage a dirty midwife because her fee is less than that of her more cleanly competitor.

The payment of a cash benefit equal to two-thirds of wages will enable the wage-earning mother to continue her usual contribution to the normal family expenses for food, rent, heat, and light, even though she be unable to continue industrial employment, either because she is physically incapacitated or because the law, as in several states, compels her to remain away from work for a prescribed period immediately before and after birth of her child. This payment will tend to prevent a lowering of the family standard of living at the time when it is most essential that the mother and baby have all the usual comforts of life.

To the nation as a whole such provision is of greater importance than protection at other times, since the conservation of the life of its future citizens at a most critical period is involved. According to Henry R. Hibbs, Jr., "the fundamental cause of the excessive rate of infant mortality in industrial communities is poverty, inadequate incomes, and low standards of living with their attendant evils, including the gainful employment of mothers."[20] The payment of the cash benefit will mitigate poverty during the period when the mother is obliged to be absent from remunerative work, and so will tend to reduce the infant mortality rate.

(4) *The Funeral Benefit Provided by This Bill Meets One of the Industrial Worker's Most Deeply Felt Needs.*

One of the needs most deeply felt by the wage-earner is provision for decent burial. A recent result of his efforts to meet this need unaided has been the issuance of large numbers of so-called industrial life insurance policies on such a basis that the worker pays

[20] Henry H. Hibbs, Jr., "Influence of Economic and Industrial Conditions on Infant Mortality," *Quarterly Journal of Economics,* November, 1915, p. 150.

"Social insurance laws offer the shortest, easiest cut to increasing the wealth of our industries. It is not a new tax. It is a new stimulus to production."—Boston Advertiser, April 26, 1916.

for the administration of this form of insurance almost as much as he is entitled to receive in benefits. "The average amount of insurance carried per policy is ridiculously inadequate to meet any of these serious economic problems" confronting the family on the death of the breadwinner, says Dr. I. M. Rubinow. "In 1881 it was $91 per policy; in 1891, $112; in 1901, $133; and in 1911, $138. . . . As a matter of fact it has been freely admitted for years that the problem which industrial insurance aims to solve, is not of 'life insurance' but of 'death insurance,' not the problem of relief for the survivors, but of a decent burial for the dead."[21] A writer in a recent number of the *American Federationist* states that "the average workingman earning $600 a year spends $13.05 a year for insurance, generally for little more than death benefits of $50 to $100."[22]

A similar range of insurance for funeral expenses is found in the payments made under American workmen's compensation acts. Of the thirty-four state laws for workmen's compensation in 1916, twenty-four allowed maximum payments of $50 to $100 for this purpose. The actual cost of burial, however, is probably much less. According to an unpublished report made to the Bureau of Social Research of the New York School of Philanthropy, if rigid economy is exercised, excluding, however, the possibility of pauper burial, the funeral of an adult in New York City may be had for $50 to $79. If less economy is exerted expenses amount to $75 or $100.[23] Thus the funeral benefit of $50 provided in the model health insurance bill represents the minimum which workers themselves attempt to lay by for funeral benefits, the minimum in the compensa-

[21] I. M. Rubinow, *Social Insurance*, p. 419.

[22] Henry Wysham Lanier, "Sickness Prevention," *American Federationist*, March 1916, p. 183.

[23] E. M. Barrows, *Cost of Burial among the Poor in New York City*, Report to Bureau of Social Research, New York School of Philanthropy, June, 1909. (Typewritten).

"That employers and the state should each contribute toward the health insurance of workers is economically sound and 'good business'. Both employers and the state, as well as the workers, profit by its results, and, after all, such insurance is only doing systematically and intelligently what is done by the old methods irregularly and to a considerable degree blindly, with much duplication of efforts and much waste of money."—New York Times, April 10, 1916.

tion laws, and the minimum cost of burial among the poor in New York City. It will meet this deeply felt need without presenting any temptation to unnecessary extravagances and without pretending to be anything more than a funeral benefit.

3. The Proposed Method of Dividing the Cost among Employer, Employee, and State Distributes the Burden of Sickness Fairly and Wisely.

The division of the contribution among the employer, the employee and the state is eminently fair since it proposes to divide the cost among the three parties responsible for illness, and since advantages will accrue to each of the joint contributors.

(1) *The Employer Is Partly Responsible for Illness and Would Benefit by Its Prevention.*

The responsibility of the employer for sickness arises from conditions in his establishment which make for ill health and for which he and not the employee is responsible. The New York State Factory Investigating Commission, for instance, found that "A great many of our industries are at present carried on under such abnormal conditions that they unduly increase the morbidity and mortality rate of the workers."[24] A later report states:

> In the production of commodities, great economies must be practised as a matter of course. But there is a tendency on the part of many employers to economize not only in matters of legitimate expense, but also in space, light, air, and certain safeguards to the health and lives of the workers. Such false economy inevitably injures the employer and imperils the health and lives of his employees.[25]

The varying effect of trade dusts in producing tuberculosis according to their degree of injuriousness, already cited, is a particularly clear illustration of the relation between occupation and health. In-

[24] *Preliminary Report of the New York Factory Investigating Commission,* 1912, Vol. I, p. 141.

[25] *Second Report of the New York Factory Investigating Commission,* 1913, Vol. II, p. 416.

"Health is not merely a good to be desired, but the very minimum foundation of a decent society. A government which ignores health insurance is not making effective to its citizens their rights to life, liberty and pursuit of happiness."—New Republic, July 22, 1916.

dustrial poisons, such as lead, arsenic, mercury, phosphorus, ammonia, and wood-alcohol, are so frequently used that out of 1,040 establishments representing 61 industries investigated in 1913 and 1914 in Ohio, industrial poisons presented a health hazard in 712 or 68.4 per cent.[26] Lead alone is used in more than 100 different industries, and a cursory investigation during 1911 of the lead-using trades in New York City resulted in the discovery of 121 relatively serious cases in that one city,[27] while a more thorough investigation in Ohio during 1913 and 1914 revealed 544 cases in that state.[28]

Not alone the substances handled, but the conditions of work, are also responsible for sickness. The ventilation of a factory, for instance, is of prime importance, and has been called the "corner stone of sanitation." In the state of New York the factory investigating commission found that of the 5,124 shops investigated but 604, or 11.8 per cent, were provided with a system of mechanical ventilation, and that it was precisely the dusty trades in greatest need of such devices which were most lax in this respect.[29] Faulty ventilation, according to Professor C.-E. A. Winslow, presents a rich field for contracting tuberculosis, for "It is not only dust that gives people tuberculosis. Bad air does the same thing more slowly, but almost as surely. *Only few workers are in dusty trades, but a great army suffer from bad air in factories and offices.*"[30]

Other working conditions, such as posture, have an important bearing upon health. As a result of special investigations the New York Factory Investigating Commission states, "The high percentage of tuberculosis among cigarmakers may be accounted for first, by the methods of work, sitting in a stooping position at narrow tables

[26] Hayhurst, *loc. cit.*, p. 105.

[27] Edward Ewing Pratt, "Occupational Diseases; A Preliminary Report on Lead Poisoning in the City of New York," *Preliminary Report of New York Factory Investigating Commission,* 1912, Vol. I, p. 369.

[28] Hayhurst, *loc. cit.*, p. 374.

[29] *Second Report of the New York Factory Investigating Commission,* 1913, Vol. II, p. 431.

[30] C.-E. A. Winslow, *The Health of the Worker,* printed and distributed by the Metropolitan Life Insurance Company for the use of its policy holders, 1913.

"We are in favor of health insurance, as is evidenced by the fact that we have had for five years a plan in effect similar to the proposed law."
—F. C. Huyck & Sons.

opposite each other and in crowded rooms; secondly, by the wretched condition of the shops in general; and thirdly, by the home work done in insanitary tenements."[31] Among garment workers, according to the study made by Dr. J. W. Schereschewsky of the United States Public Health Service, 58.4 per cent of 1,073 men had a "bad posture," while 50.3 per cent of 2,086 men and 20.5 per cent of 1,000 women had spinal curvatures. A completely straight spine was rarely found by the examiners. The conclusion reached was that "while the garment trades in themselves did not necessarily induce faulty posture provided the postural habits of the worker were originally correct, occupation in the garment trades had a strong tendency to intensify incorrect postural habits."[32]

Fatigue, to which many workers are peculiarly subject because of long hours of work and the increasing strain of modern industry, is a predisposing cause of disease, "because if unrepaired, it undermines vitality and thus lays the foundations for many diseases."[33] Foundations are thus laid not alone for degenerative diseases brought on by over-exertion and the accumulation of waste products within the system, but also for diseases due to infection, since the lowered vitality of the system is less able to resist the onslaught of bacteria.[34] The greatest number of accidents and sicknesses occur, according to investigations of German insurance authorities, precisely in those factories in which the hours of work are the longest.[35]

The expense of sickness due to these and similar occupational hazards should be borne by industry as a part of the cost of production. It is as legitimate an overhead charge as that made for machinery and shop repairs. Already the cost of a part of the wear

[31] *Second Report of the New York Factory Investigating Commission,* 1913, Vol. II, p. 500.

[32] J. W. Schereschewsky, "Studies in Vocational Diseases: The Health of Garment Workers," United States *Public Health Bulletin,* No. 71, May 1915, pp. 65, 61, 67, 69, 70, 73.

[33] Josephine Goldmark, Oregon ten hour case previously cited, p. 64.

[34] Josephine Goldmark, *Fatigue and Efficiency,* 1912, p. 111.

[35] Frankel and Dawson, *loc. cit.,* p. 242.

"State or national health insurance ought to appeal to the industrial leaders and to the financiers, just as it does to the ruling people in Europe. It is an insurance of themselves also against disease and an insurance of increased industrial efficiency and of increased social contentment."—Detroit (Mich.) Journal, June 6, 1916.

and tear of human lives has been placed upon industry through workmen's compensation legislation, and is being passed on to the consumer in the price he pays for the product. It is but just that the entire cost of the sickness for which industry is responsible should be included in the cost of production.

The return to the employer in a healthier and more efficient labor force also makes his share of the contribution a matter of justice. This return has been realized by German employers who are quoted in an official British white paper as stating:

> According to our observation the employers willingly bear the costs which the insurance laws impose on them, and it is doubtful whether a single employer would wish to be without these laws so far as the cost goes. The laws "pay" employers from their own standpoint.[36]

The improved mental efficiency of the worker when one of his chief sources of worry is removed is likewise a source of benefit to the employer. Dr. Spieker, chairman of the League of German Employers' Associations, sums up this point in the telling words:

> The task of the employers' associations in this field is a blessing not only to the workers, but to the industries. It is perfectly evident to-day that we have secured higher efficiency in our industries due to increased workers' efficiency, all brought about by relieving our workers from worries and distress on account of sickness, injury, superannuation and invalidity.[37]

American employers also are growing to realize the advantages which come from a healthy labor force. Mr. Howell Cheney states that his company, Cheney Brothers, has been actuated in contributing to a sick benefit fund for its employees by the following considerations:

> First, it was an extension of the company's past system of relief to individuals and tubercular patients, so that it was not entirely dependent upon charity but was an encouragement to the efficient and provident employee who was willing to make a sacrifice to secure the additional

[36] *Insurance Legislation in Germany,* copy of memorandum containing opinions of various authorities in Germany, Cd. 5679 of 1911.

[37] Schwedtman and Emery, *Accident Prevention and Relief,* 1911, pp. 278-279.

"A careful investigation would show that conditions imposed upon many workmen are responsible for much of the sickness.....and it is only fair that the employer under such conditions should be responsible for the health of his employees."—The Insurance Advocate, February, 1916.

benefits guaranteed. Secondly, it covered whatever slight occupational disease or unsanitary conditions might be connected with the industry, which its members were powerless to protect themselves against. Third, illness as well as injury occasion a large economic waste to the company as well as to the employees on account of lost time, idle machinery, and ineffective work. It is to the direct interest of the company as well as the individual to bring about a reestablishment of health, and consequently efficiency, by supplying the best conditions possible for recovery.[38]

A similar opinion is held by the directors of the American Telephone and Telegraph Company who in their report to stockholders for 1915 say in speaking of their employees' benefit fund:

> We believe it is no more than simple justice that the men and women who devote their working lives to the telephone service should be assured of some income when they are sick or come to old age, and that some immediate provision should be made for those dependent on such workers when they die in the service. If justice demands this, its cost is a fair charge against the business, and we so regard it. Besides the matter of justice a suitable provision for these exigencies of life which the wage-earner is frequently unable to meet single-handed relieves him of anxiety and dread and enables him when sick to secure the care and treatment which he needs. The payment of the benefits thus brings a very real return through the employee's increased efficiency and interest in the service. Evidences of this and of its beneficial effect on the telephone service appear continually. The telephone-using public is benefitted as well as the telephone employees.

The employer's duty to care for the health of his employees, and the gain to him through so doing, have received legal recognition. Thus in People *ex rel* Metropolitan Life Insurance Company *v.* Hotchkiss (136 Appellate Division, New York, 154) the court says: "It is well within the corporate power to assume the care and treatment of such of its employees as are afflicted witih tuberculosis. . . . The reasonable care of its employees according to the enlightened sentiment of the age and community is a duty resting upon it and the proper discharge of this duty is merely transacting the business of the corporation." Other cases present the same point of view.

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[38] Howell Cheney, "Plans Adopted by Cheney Brothers for Industrial Insurance and Old Age Pensions," in Schwedtman and Emery, *loc. cit.*, p. 411.

"There is not the slightest doubt that sickness insurance will be created by statute in this state before many years have gone by."—California State Medical Journal, May, 1916.

(2) *The Wage-Earner Is Partly Responsible for Illness and Would Benefit by Its Prevention.*

The responsibility of the employee for illness is seen in the conditions over which the individual has a certain degree of control, such as diet and mode of life.

Since the individual is in part responsible for illness, it is only just that he bear that portion of the burden not due to occupational hazard, with such help as the state may supply for public reasons. In this respect health insurance is unlike workmen's compensation, for illness of wage-earners does not all arise directly "out of and in the course of employment." There is a minimum of sickness for which the employee and not the employer should pay. Moreover, the personal gain to the employee from his improved health, and from the cash benefits received in time of illness, further justify his share in the joint contribution.

(3) *The State Is Partly Responsible for Illness and Would Benefit by Its Prevention.*

There remains a third group of conditions influencing health, such as the protection of water, milk and food supply, housing regulation, street cleaning, garbage and sewage disposal, and control of contagious diseases, for which the state is responsible. Thus George A. Johnson, consulting engineer, states that if the urban population of the United States were supplied with filtered water, or water of equal purity, the typhoid fever rate would be so reduced that "about 3,000 lives would be saved annually, and 45,000 cases of typhoid fever prevented."[39] For such unprevented illness the state should shoulder a portion of the financial burden. The state, too, will reap an advantage in the better health of its citizens resulting from increased facilities for medical care on a basis which all can afford and from the improved financial status of the family during the illness of the breadwinner.

[39] George A. Johnson, *The Typhoid Toll*, address before the American Water Works Association, June 9, 1916.

"Nothing is more certain than that prevention will take the place of treatment for cure, when it is plain to the employer and the employee that it costs him less to take precautions to avoid sickness than it does to pay the bills for medical service, after sickness is incurred."—Haven Emerson, M.D., Commissioner of Health, New York City.

(4) *The Proposed Distribution of Cost Will Put Health Insurance Within Reach of Those Who Otherwise Would Lack It.*

Besides being eminently just the proposed distribution of the burden of sickness has the additional advantage of placing health insurance within the reach of all wage-earners. The inability of many wage-earners to bear the entire cost of sickness insurance has been previously brought out. Only under compulsory insurance in which employer and state both pay a fair share is it possible to relieve the worker of a considerable portion of the cost.

(5) *The Proposed Division of Cost Between Employer and Employee Offers the Advantages of Democratic Control.*

Moreover, administrative advantages accrue from a wise division of the expense between employer and employee. In the model bill the contributions of the worker and the employer are equal, each paying 40 per cent of the cost. This distribution makes it possible to divide the control of the funds equally between employer and employee, since both are equally interested in economical and efficient management of the sums they have accumulated through joint contributions. To the employer this means that the organizations will not be dominated by a small coterie of radical workers who may not be guided by sound business principles; to the employee it means that the control of the funds will not rest with a group of business men eager to cut down benefits unduly in order that the contributions may be decreased. Control of the insurance funds has proved of so much importance in Germany that the employers are eager to pay 50 per cent of the cost in order to secure equal voice with the employees in the management in exchange for the present one-third control corresponding to their contributions of 33⅓ per cent.[40] The employees, on the other hand, who bear two-thirds of the expense, prefer this higher proportionate payment accompanied by a proportionate control in the administration.[41] Justice to both

[40] Schwedtman and Emery, *loc. cit.*, p. 59.

[41] W. H. Dawson, *Social Insurance in Germany*, p. 260.

"The obligation of the employer to insure will serve to call his attention to the cost of sickness and will be a strong incentive to more care in conducting his industry and more attention to sanitary methods and precautions."—Dr. Alice Hamilton, United States Bureau of Labor Statistics.

parties can only be achieved if the control be truly mutual and based upon their equal financial interest.

4. Health Insurance Will Stimulate the Needed Campaign for the Prevention of Illness.

The cash benefit equal to two-thirds of wages which will be payable under health insurance for each week of disability among large groups of workers will call attention forcibly to the cumulative financial loss involved in sickness, a loss which to-day is not brought home to the public because it is borne in silence by scattered individuals. The money benefit will set a cash value upon health, and will thereby stimulate the needed campaign for the prevention of illness.

Factory sanitation, for instance, will be developed. The system of financing adopted in the bills introduced in the legislatures of Massachusetts, New York, and New Jersey in 1916 make the incentive very direct. The contributions must be calculated so as to suffice for the payment of benefits and for administrative expenses; thus contributions may vary from year to year with an increase or a decrease in the amount of sickness. Since the insurance unit is the locality or a single trade, a high sickness rate in a community or a trade will be noticed at once by the employers in the high contribution; the prospect of decreasing the contribution by reducing sickness will make for the prevention of illness through the means most readily at the command of the employer, namely, improvements in factory sanitation. Where several industries are insured in one fund financial pressure can still be brought to bear upon each industry by varying the contribution to correspond with the sickness rate in each industry. Even the individual establishment which has an excessive rate of sickness can be reached by assessing an additional contribution upon such an employer without right of deduction from the employee. Thus the high cost of insurance will call attention both to an excessive amount of sickness and to the possibility of reducing expenditure on insurance premiums through the prevention of sickness. The interest of the employer in prevention of disease and in improved sanitation will at once be enlisted.

"The most direct incentive for the promotion of [factory] sanitation would be the adoption of a proper system of sickness insurance."—Final Report of the Commission on Industrial Relations, 1915.

The power of health insurance to stimulate factory hygiene has been noted by Dr. Lee K. Frankel, who, in a paper entitled "Industrial Insurance the Basis of Industrial Hygiene," says:

> It was an obvious sequence of such provisions [i.e. compensation for industrial disease under accident insurance] that factories and other industrial establishments should be put in the best possible sanitary condition, particularly in order to avoid the presence of dust, impure air, insufficient lighting, and so forth, since it was recognized that these conditions led to impaired health of workmen. . . . The wonderful industrial development in Germany in the last twenty-five years can unquestionably be attributed, in large measure, to the social-insurance scheme which prevails there, and which has taught the employer, as well as the employee, the utility of work under conditions which maintain health and prevent useless and avoidable injury and disease.

And Dr. Frankel concludes: "Our need in the United States is the cultivation of the principle of prevention as applied to sickness and invalidity, similar to the beginnings which have been made in insurance against fire and accident. Before this can be done, however, we must have a comprehensive scheme of insurance against the consequence of sickness and invalidity."[42]

Enlightening, also, is the activity of the medical research committee connected with the administration of the British health insurance act. Under the auspices of this body a "Special Investigation Committee upon the Incidence of Phthisis in Relation to Occupations" has issued a valuable report including recommendations for factory and other activities calculated to prevent tuberculosis among boot and shoe workers.[43]

That in this country, as well as abroad, a decided improvement in factory hygiene may be looked for following the introduction of health insurance is shown by the American experience with work-

[42] Lee K. Frankel, "Industrial Insurance the Basis of Industrial Hygiene," *Transactions of the Fifteenth International Congress on Hygiene and Demography*, Washington, 1912, Vol. III, Part II, pp. 893, 896.

[43] Medical Research Committee, *First Report of the Special Investigation Committee upon the Incidence of Phthisis in Relation to Occupations, 1915.*

"The great merit of the proposed legislation is the contribution it is certain to make to the cause of health conservation. Under this scheme health comes to have a cash value, not only to the employee, but to the employer and the state, since all must contribute to the insurance fund."
—Henry R. Seager, Professor of Economics, Columbia University.

men's compensation. The introduction of this legislation has stimulated the widespread movement for "Safety First" which has resulted in a material reduction in the number of accidents. For instance, the Schenectady plant of the General Electric Company between 1913 and 1915 reduced by 34 per cent accidents causing a loss of time amounting to more than the remainder of the shift in which the accident occurred; in the same two years the Lackawanna Steel Company reduced all accidents involving loss of time by 44 per cent; during this period the Eastman Kodak Company in its Kodak Park plant effected a reduction of 56 per cent in all accidents occasioning loss of time; while the American Locomotive Company in the same two years reduced accidents causing a loss of five hours or more by 62 per cent.[44]

Preventive medicine also will be stimulated by health insurance. In the present day campaigns against tuberculosis, cancer, and degenerative diseases, early diagnosis is a recognized essential. Periodic physical examinations are one of the best methods of assuring that each person gives the physician opportunity to detect diseases while they are still in the incipient stage. But as has previously been pointed out, many industrial workers can not afford a physician even when ill, and will be much less likely to consult one when health is apparently normal. The physical examination now in vogue for employees at some establishments may seem at first to offer a solution. Reflection, however, shows that since these examinations are dependent upon the initiative of the employer they will be confined to a limited number of establishments. Moreover, since this examination does nothing more than reveal defects and fails to provide the necessary treatment, which

[44] New York State Department of Labor, "Industrial Accident Prevention," *Special Bulletin No. 77*, May 1916, pp. 13, 12, 9, 5.

"The strongest of incentives—that of lessening cost—is given to efforts to diminish frequency and seriousness of losses; sickness insurance in this respect is a preventive measure of a positive and direct kind. . . . Sickness insurance is no longer experimental, but is rapidly becoming universal."—Final Report, U. S. Commission on Industrial Relations; signed, among others, by John B. Lennon, Treasurer, American Federation of Labor; James O'Connell, Second Vice-President, American Federation of Labor; Austin B. Garretson, President, Order of Railroad Conductors.

many workers cannot afford, it too frequently is of little permanent benefit to the examined worker.

The opportunity both for physical examination and for treatment is provided by the medical benefit available under health insurance. Furthermore,

> The workmen's present objections to medical examinations conducted by physicians hired by employers would disappear when the examinations were undertaken by a staff of independent physicians employed by the insurance funds. The loss of employment on account of ill health will be more than counterbalanced by the opportunities for quick recovery when we have a system of compulsory health insurance through which every workman suspended on account of physical unfitness will be entitled to sick benefit administered not by the employer and his hired physician alone, but by representatives of employer, employee and the state.[45]

Discrimination against workmen who are ill is less likely to develop when employers are brought to realize the economy of keeping trained men and returning them quickly to work, and when the burden of insurance is borne not by each employer separately, but by all in the trade or local group so that he indirectly continues to contribute as long as the man is employed by any member of the fund.

Moreover, the revelation of the real needs of the wage-earning population may be expected to stimulate here, as it is doing in Great Britain and as it has done in Germany, more adequate medical machinery for the prevention of disease. For instance the German invalidity funds which pay benefit for prolonged periods of incapacity have found, according to investigations in 1896 and 1899, that tuberculosis of the lungs holds third position as the primary cause of invalidity among men, and second position as the primary cause of invalidity among women.[46] This has led the German insurance funds to take an active part in the anti-tuberculosis crusade and, in

[45] John B. Andrews, "Physical Examination of Employees," *American Journal of Public Health,* August 1916.

[46] Frederick L. Hoffman, "Care of Tuberculous Wage-Earners in Germany," United States Bureau of Labor, *Bulletin No. 101,* p. 63.

"A governmental system of health insurance can be adapted to American conditions, and when adapted will prove to be a health measure of extraordinary value."—B. S. Warren, Surgeon, U. S. Public Health Service; Edgar Sydenstricker, Public Health Statistician, U. S. Public Health Service.

the opinion of Dr. Bielefeldt, "The conviction may be expressed, after the experience of several years, that an effective battle against consumption among the working classes would have been all but impossible without the workmen's insurance of the German empire, and by the support of their powerful pecuniary resources, and with the aid of national social regulations, in the end we are quite certain to be victorious."[47]

Popular education on disease prevention may form one of the activities of the insurance funds. In Germany, according to W. H. Dawson,

> The popular lectures, given in public halls or at trade union headquarters, are regarded as one of the most effective ways of securing the cooperation of the working classes in the crusade against disease. The central committee of the sick funds of Berlin which devotes great attention to this subject arranges for regular courses of lectures to be given by prominent medical practitioners in all parts of the city on the causes, symptoms, treatment and prevention of various diseases to which men and women respectively are particularly prone.[48]

Education on the prevention and treatment of tuberculosis has also been inaugurated in the brief history of the British act. Several of the more progressive insurance committees have arranged for courses of lectures, and one committee has made arrangements with twenty moving picture shows to exhibit films showing the treatment of tuberculosis actually offered to the people of the district.[49]

Governmental interest in comprehensive campaigns for sickness prevention will be intensified through the increase in the state contribution to the sick funds with an increase in the amount of illness. The possibilitiy of reducing this appropriation will impel the state administration toward more extensive public health work. More powerful, probably, will be the activities of the local and trade funds in attacking local causes of sickness. For instance the German sick funds, notably the Berlin Sick Fund of Merchants, Tradesmen, and Apothecaries, have ascertained through their sick visitors

[47] Quoted in above, p. 23.

[48] W. Harbutt Dawson, *Social Insurance in Germany*, pp. 183-184.

[49] *National Insurance Gazette*, December 20, 1913; February 14, 28, April 11, May 23, June 13, 1914.

"No other social movement in modern economic development is so pregnant with benefit to the public."—Journal American Medical Association, May 6, 1916.

the housing conditions of sick members. "Although," in the opinion of the German Imperial Insurance Office, "such investigations do not immediately reform all the evils, still their disclosure and publication and information given to the police, landlords, poor and school doctors and also to hospitals and tuberculosis sanatoria will help to improve the situation. The occupants of the dwellings are also informed of the probable cause of illness and are told of the necessity of sanitary lodgings."[50] Housing reform has also been promoted by the German invalidity funds which have large reserves to invest.

The actual increase in longevity of the German people during the operation of the insurance system is brought out in the accompanying table from the report of the National Conservation Commission, which shows that the rate at which life has lengthened in Prussia has been nearly twice as great as in other countries:

RATE OF LENGTHENING LIFE, IN YEARS PER CENTURY

Country	*Periods*	*Males*	*Females*
England	1871-1881 to 1891-1900, or 20 years	14	16
France	1817-1831 to 1898-1903, or 76 years	10	11
Prussia	1867-1877 to 1891-1900, or 23 years	25	29
Denmark	1835-1844 to 1891-1900, or 57 years	13	15
Sweden	1816-1840 to 1891-1900, or 67 years	17	15
United States: Massachusetts	1855 to 1893-1897, or 40 years	14	
India	1881 to 1901, or 20 years	0	

"It is probably no accident," states the commission in commenting on this progress, "that the maximum rate obtains in Prussia which is probably the most progressive country in the discovery and application of scientific medicine."[51]

Thus compulsory health insurance not only meets the urgent need of the wage-earner for medical care and for financial assistance during illness, but, of the various possible methods of insuring, it alone promises to distribute the cost fairly and wisely between employers,

[50] *The German Workmen's Insurance as a Social Institution*, Compiled by order of the Imperial Insurance Office for the St. Louis Exposition, Part IV, p. 24.

[51] National Conservation Commission, Report on National Vitality: Its Wastes and Conservation, p. 102.

"Through the establishment of health insurance, campaigns for "Health First" will spring up, as did those for "Safety First."—New York Tribune, March 14, 1916.

employees and the state, while it also offers peculiar administrative advantages and can be counted on to give a powerful stimulus to the prevention of sickness. Compulsory health insurance is at once an economical method of providing for the needs of the wage worker and a mighty force for the inauguration of a comprehensive campaign for health conservation.

"Undoubtedly some such arrangement for the protection of workmen and their families against the sufferings consequent to illness and accident must come as a development of the present social trend. Already some dozen of countries in Europe have successfully instituted and maintained such health insurance without in a single instance a confession of failure or abandonment of the effort to solve this serious problem."—New York Herald, February 9, 1916.

HEALTH INSURANCE STANDARDS

1. To be effective health insurance should be compulsory, on the basis of joint contributions of employer, employee and the state.

2. The compulsory insurance should include all wage workers earning less than a given annual sum, where employed with sufficient regularity to make it practicable to compute and collect assessments. Casual and home workers should, as far as practicable, be included within the plan and scope of a compulsory system.

3. There should be a voluntary supplementary system for groups of persons (wage workers or others) who for practical reasons are kept out of the compulsory system.

4. Health insurance should provide for a specified period only, provisionally set at twenty-six weeks (one-half year), but a system of invalidity insurance should be combined with health insurance so that all disability due to disease will be taken care of in one law, although the funds should be separate.

5. Health insurance on the compulsory plan should be carried by mutual local funds jointly managed by employers and employees under public supervision. In large cities such locals may be organized by trades with a federated bureau for the medical relief. Establishment funds and existing mutual sick funds may be permitted to carry the insurance where their existence does not injure the local funds, but they must be under strict government supervision.

6. Invalidity insurance should be carried by funds covering a larger geographical area comprising the districts of a number of local health insurance funds. The administration of the invalidity fund should be intimately associated with that of the local health funds and on a representative basis.

7. Both health and invalidity insurance should include medical service, supplies, necessary nursing and hospital care. Such provision should be thoroughly adequate, but its organization may be left to the local societies under strict governmental control.

8. Cash benefits should be provided by both invalidity and health insurance for the insured or his dependents during such disability.

9. It is highly desirable that prevention be emphasized so that the introduction of a compulsory health and invalidity insurance system shall lead to a campaign of health conservation similar to the safety movement resulting from workmen's compensation.

HEALTH INSURANCE

TENTATIVE DRAFT OF AN ACT

Submitted for Criticism and Discussion by the

COMMITTEE ON SOCIAL INSURANCE

OF THE

AMERICAN ASSOCIATION FOR LABOR LEGISLATION

The British title, "Health Insurance," is used instead of the German "Sickness Insurance," because it calls attention to the main object of the act, the conservation of health, that is, the prevention and treatment of sickness, as well as provision of financial benefits.

Section 1. TITLE. This chapter shall be known as the Health Insurance Act.

Section 2. DEFINITIONS. When used in this act:

"Commission" means the Social Insurance Commission;

"Fund" means a local or trade fund, as the case may be;

"Society" means an approved society;

"Carrier" means the society or fund which carries the insurance;

"Insurance" means health insurance under this act;

"Disability" means inability to pursue the usual gainful occupation.

PERSONS INSURED

The principle of compulsion has been adopted because authorities are pretty generally agreed that this is the only method to reach the poorest paid and the most improvident workers, who obviously most need the benefits offered by an insurance scheme. Thus in Great Britain, where voluntary sickness

insurance had an exceptional development, only the better paid workers were insured, and it was found necessary in 1911 to enact a compulsory measure to give the whole population the necessary protection. In addition, compulsion to insure reduces the administrative expenses otherwise involved in canvassing for business; thus in Great Britain the administrative cost of the compulsory health insurance law is but 14 per cent of the receipts, whereas the societies which collect from house to house small premiums for burial insurance spend 37 per cent of their total income for management. Compulsory insurance, through the certainty that each fund will have a regular accession of young lives every year, allows the younger members who have overpaid in their youth to benefit in old age by the overpayments of the incoming generation, does no injustice to the individual worker, and therefore makes possible the avoidance of the reserve fund of private insurance. These savings make it possible to offer larger benefits for the same contributions than would be possible under voluntary insurance.

Moreover, European experience is strongly in favor of compulsion, and in no country in which it has been introduced has it been subsequently abandoned. Even in the United States compulsion is not unknown, for compulsory hospital funds are very common in the mining regions and on railways, affecting thus the highest as well as some of the lowest paid labor in the country.

Employed persons only are included, except that medical attendance is to be given to the families. The wage-earner is usually the breadwinner of a family; his illness is normally an economic as well as a physical misfortune;

his needs are therefore different from those of the classes not so directly dependent on health for their livelihood, or those of the non-wage-earning members of a family.

German and English precedents are followed by including under compulsory insurance all manual workers, whatever their earnings, and in limiting compulsory insurance for other employees, mostly clerks and foremen, to persons earning less than $1,200 a year. (Sec. 3.) The only exception to the general rule of compulsion is made for the case of home workers and casuals. Where a person works only occasionally, his contributions would be so few and scattered as not to form a proper basis for his benefits, and he will usually be dependent either on other members of his family, on other means, or on charity. Power should be vested in a public authority to make special provision for or to exempt any such cases from the insurance by a general regulation. (Sec. 4.) Following all European acts, provision is made for voluntary insurance of practically all working people not under compulsory insurance, and of small employers. It is particularly desirable that former employees who have been long insured should be enabled to continue their insurance. Voluntarily insured persons have the right to enter the compulsory mutual funds, and so to participate in their benefits and management. (Secs. 5, 35.)

Section 3. COMPULSORY INSURANCE. Every person employed in the state at manual labor under any form of wage contract, unless exempted under Section 4 of this act, and every other employee whose remuneration does not exceed $100 a month, shall be insured in a fund or society, except employees of the United States and except employees of the state or of munici-

palities for whom provision in time of sickness is already made through legally authorized means which in the opinion of the Commission are satisfactory.

Section 4. HOME WORKERS AND CASUAL EMPLOYEES. Special regulations shall be made by the Social Insurance Commission for the insurance of home workers and casual employees, or for their exemption from compulsory insurance.

Section 5. VOLUNTARY INSURANCE.

Self-employed persons whose earnings do not exceed $100 a month on an average;

Persons formerly compulsorily insured who, within one year from the date on which they cease to be insured, apply for voluntary insurance;

Members of the family of the employer who work in his establishment without wages;

may insure themselves voluntarily in the local or trade funds of the locality in which they live and of the trade at which they are employed, subject to conditions of this act.

BENEFITS

When the breadwinner of a family falls ill, he needs not only medical care, but also, usually, a sufficient cash benefit to insure the support of himself and of his dependents. It is essential that the two benefits be associated in the same organization, both for economy and convenience of administration, and also to meet effectively the abuse of malingering. The public interest in the insurance, the improvement of the health of a large and peculiarly threatened class of the community, can only be adequately met by the provision for medical attendance. The same public interest demands the extension of this benefit to the dependent members of the families of the insured, provided for in American hospital funds and in German sick insurance organizations. The state's subsidy is designed in

part to cover the expense of this extension which would not constitute a large percentage of the total cost. (Secs. 6-17.)

Proper provision for medical care is one of the most important problems in the efficient administration of health insurance. The tentative plan—many of the details of which should be left to regulations to be made by the Commission and the medical advisory board—allows each fund or approved society to select the method of administration suitable to local conditions. Where the fund chooses the panel system, any legally qualified physician may join the panel, and the insured workmen shall have free choice among physicians undertaking insurance practice. Since this system may not prove practicable in all districts, freedom should be left to the funds to provide medical care through other methods, such as salaried physicians, among whom there should be reasonable free choice, through physicians responsible for specified districts, or through any other method approved by the Commission. (Secs. 9-11.)

To avoid some of the recognized shortcomings of foreign systems, certain safeguards have been inserted. For instance, the limitation placed upon the number of insured patients whom a physician may treat will go far toward preventing a repetition of the British experience whereby, under a system of free choice of physician, one-fifth of the doctors are, in many towns, treating one-half the insured population. Moreover, since this limitation is calculated with reference to the probable number of sick days which a doctor is likely to have in charge, it will prevent extreme cases of overwork caused by

too large numbers of insured patients. In the interests of patients, doctors, and funds alike, it is highly desirable to separate the duty of certifying a person as eligible for cash benefit from that of treating him, and for this and for supervisory purposes a fund may employ a medical officer. (Sec. 11.)

The question of method of payment to physicians is an especially complex one on which the committee has not reached definite conclusions, although it offers the following points for discussion:

The capitation payment, of so much per person per year, common now in lodge practice, has in it elements which bring about an undue amount of work, and in turn forces neglectful, hurried service to the patients. Another plan is that of engaging a salaried physician, similar to the arrangements now made by many railroads. Since no fund could employ many physicians, the limited choice of doctor might be unfavorably regarded by some of the insured persons. The advocates of this system claim that it offers peculiar advantages of selecting the physicians most desirable for this work, and thus of obtaining better service. A third method, payment per visit, is also possible. To the medical profession this method may be preferable because it establishes a quantitative relation between services and remuneration, and to the patient because it probably secures more careful attention from the doctor and thus eliminates the chief fault of the capitation system. On the other hand, medical care under this system may put a heavier burden upon the funds administering benefits. A compromise between this and capitation may be made by which a total sum, calculated on the per

capita basis, is distributed among physicians in accordance with the services rendered by each. Instead of the elaborate fee schedule common under workmen's compensation, a more simple arrangement is made whereby a physician is paid pro rata for office and house visits. Although this effectively meets the chief objection to a capitation payment, it may be undesirable to the physician since the actual payment for each visit may decrease in proportion as work increases. However, the provision of a fixed amount divided according to services has administrative advantages since the total amount paid for medical aid is a fairly constant charge upon each fund.

But whichever system be adopted, one thing is clear: all medical service to the insured will be paid for, including the unremunerated dispensary practice of to-day. The problem becomes one of deciding which method of arranging for the 100 per cent collections of the future is preferable, in the interests alike of patients, doctors, and administrators.

Representation of the medical point of view in the administration is important. This need is met by the presence of a doctor on the Social Insurance Commission and by provision for consultation with representatives of the medical profession on medical matters. This secures a hearing to the medical point of view on both state and local problems.

The necessary supervision may be obtained through medical officers employed by the funds, while matters in dispute may be referred to special committees, both state and local. To these committees, representing the various interests, power might well

be given to remove undesirable practitioners from insurance practice, subject to an appeal to the Commission.

Provision for maternity benefit is included, since childbirth may be assimilated with sickness in its physical and economic effects, and since the interest of the public in better care of mothers is clear. The prohibition placed in some states upon the industrial employment of women just before or after childbirth, in addition to the financial loss involved in her absence from work emphasizes the desirability of providing a cash benefit during her inability to work just as cash benefit is provided for incapacity for other causes. Moreover the annual occurrence in the registration area of 10,000 deaths of mothers from causes connected with childbirth and of 52,000 deaths of infants from diseases of early infancy—many of which are preventable—make it imperative to provide more adequate care. The importance of this provision is reflected in the fact that maternity benefits are universally included in European systems. Provision for maternity benefit has always been a feature of the model Health Insurance bill. In an effort to meet objections from one source, however, this feature was left out of the bills as introduced in 1916. This omission led to much adverse criticism. (Sec. 18.)

Funeral benefits are the most urgently felt insurance need of the classes subject to this act. They are included in most compulsory foreign systems, and are provided for in most systems existing in America. As one of the benefits under sickness insurance, their cost would be very small in proportion to what it is at present, and also in proportion to the

total amount of benefits. The present great cost of premium collection for burial insurance will be done away with and the added cost of administration of the system will be negligible, while the relief afforded to the poorer classes of working people, in comparison to the heavy cost of securing burial insurance at present, will go far towards paying their share of the contributions for all benefits. (Sec. 19.)

Section 6. CASES IN WHICH PAID. Insured members shall receive benefits in case of any sickness or accident or for death, not covered by workmen's compensation.

Section 7. MINIMUM BENEFITS. Every carrier must provide for its insured members as minimum benefits:

Medical, surgical and nursing attendance;
Medicines and surgical supplies;
Cash benefits;
Maternity benefits;
Funeral benefit;
Medical and surgical attendance and medicines for dependent members of their families.

Section 8. BEGINNING OF RIGHT. Insurance, with the exception of maternity benefits, begins with the day of membership. The maternity benefits shall be payable to any woman insured against sickness for at least six months during the year preceding the confinement, or to the wife or widow of any man so insured.

Section 9. MEDICAL, SURGICAL, AND NURSING ATTENDANCE. All necessary medical, surgical and nursing attendance and treatment shall be furnished by the carrier from the first day of sickness during the continuance of sickness but not to exceed twenty-six weeks of disability in any consecutive twelve months. In case the carrier is unable to furnish the benefit provided for in this section, it must pay the cost of such service actually rendered by competent persons at a rate approved by the Commission.

Section 10. MEDICAL SERVICE. The carriers, subject to the approval of the Commission, shall make arrangements for medical, surgical, and nursing aid by legally qualified physicians and surgeons, and by nurses or through institutions or associations of physicians, surgeons, and nurses. Provision for medical aid shall be made by the carriers by means of either:

1. A panel of physicians to which all legally qualified physicians shall have the right to belong, and from among whom the patients shall have free choice of physician, subject to the physician's right to refuse patients on grounds specified in regulations made under this act; provided, however, that no physician on the panel shall have on his list of insured patients more than 500 insured families nor more than 1,000 insured individuals;
2. Salaried physicians in the employ of the carriers among which physicians the insured persons shall have reasonable free choice;
3. District medical officers, engaged for the treatment of insured persons in prescribed areas;
4. Combination of above methods.

Section 11. MEDICAL OFFICERS. Each carrier shall employ medical officers to examine patients who claim cash benefit, to provide a certificate of disability, and to supervise the character of the medical service in the interests of insured patients, physicians, and carriers.

Section 12. MEDICAL AND SURGICAL SUPPLIES. Insured persons shall be supplied with all necessary medicines, surgical supplies, dressings, eyeglasses, trusses, crutches and similar appliances prescribed by the physician, not to exceed $50 in cost in any one year.

Section 13. HOSPITAL TREATMENT. Hospital or sanatorium treatment and maintenance shall be furnished, upon the approval of the medical officer of the carrier, instead of all other benefits (except as provided in Section 16), with the consent of the insured member, or that of his

family when it is not practicable to obtain his consent. The carrier may demand that such treatment and maintenance be accepted when required by the contagious nature of the disease, or when in the opinion of its medical officer such hospital treatment is imperative for the proper treatment of the disease or for the proper control of the patient. Cash benefit may be discontinued during refusal to submit to hospital treatment. Hospital treatment shall be furnished for the same period as cash benefit. This benefit may be provided in those hospitals with which the funds and societies have made satisfactory financial arrangements which have met the approval of the Social Insurance Commissioners, or in hospitals erected and maintained by the funds and societies with the approval of the Commission.

Section 14. ARBITRATION COMMITTEE. All disputes between the insured and physicians, or between funds and physicians concerning medical benefits shall be referred to special committees composed of representatives of the interests concerned with an impartial chairman appointed by the Commission, with an appeal to the Commission.

Section 15. CASH BENEFIT. A cash benefit shall be paid beginning with the fourth day of disability on account of illness; it shall equal two-thirds (66-2/3 per cent) of the weekly wages of the insured member. It shall be paid only during continuance of disability, and shall not be paid to the same person for a period of over twenty-six weeks in any consecutive twelve months.

Section 16. CASH BENEFIT TO DEPENDENTS. A cash benefit equal to one-third of the wages of an insured member receiving hospital treatment shall be paid to his family or other dependents while he is in the hospital.

Section 17. PERIODS OF PAYMENT. Cash benefit shall be paid weekly where possible, and in no case less frequently than semi-monthly.

Section 18. MATERNITY BENEFITS. Maternity benefits shall consist of:

All necessary medical, surgical and obstetrical aid, materials and appliances, which

shall be given insured women and the wives of insured men;

A weekly maternity benefit, payable to insured women, equal to the regular sick benefit of the insured, for a period of eight weeks, of which at least six shall be subsequent to delivery, on condition that the beneficiary abstain from gainful employment during period of payment.

Section 19. FUNERAL BENEFIT. The carrier shall pay the actual expenses of the funeral of a deceased insured member, as arranged for by the family or next of kin, or in absence of such by the officers of the fund, up to the amount of $50. The funeral benefit shall be paid in case of death of a former member while in receipt of cash benefits, or death within six months after discontinuance of cash benefits because of the exhaustion of the time limit, provided he has not, within those six months, returned to work.

Section 20. ADDITIONAL BENEFITS. The carriers may grant additional or increased benefits, with the consent of the Commission.

Section 21. EXTENSION OF INSURANCE. When contributions cease on account of unemployment not due to sickness, the insurance shall continue in force for one week for each four weeks of paid up membership during the preceding twenty-six weeks.

CONTRIBUTIONS

If a mutual organization of employers and employees is to manage the insurance under the supervision of the state, it is important that the two elements should feel a concern in keeping down the sickness rate and in preventing malingering. The most effective way of securing this result is to divide the pecuniary burden and thus make any increase in cost immediately felt by all parties concerned, so that the representatives of the various interests on the governing boards of the mutuals would be required

to show reasons for and results from their expenditures. The influence of the employees as recipients of benefits, and state supervision, will prevent undue decrease of benefits, while the interest of employees both as contributors and as recipients of benefits, joined to the interest of employers as contributors, will tend to prevent extravagance and fraud. The contribution of the state will not only justify state regulation, but will interest the public at large and state departments in the promotion of the public health.

If employers and employees are to have an equal share in the administration of the mutual funds, their contributions should be equal. The share of the state, one-fifth, is enough to interest the public in the results of the insurance, while it is not so large a share of the actual cost that its temporary withdrawal by an economical legislature or executive would fatally cripple the insurance fund. (Sec. 22.)

More weighty than the argument of expediency is that of justice. The state now recognizes its duty as a guardian of the health of those of its people less able to care for themselves, by factory and housing laws, by free hospitals and dispensaries supported by municipalities and resorted to by a large and ever-growing proportion of the poorer classes; the common danger from communicable diseases has made increasingly clear the benefit to all from a broad and effective health campaign. Why should not the general public, through the state, contribute to what has proved in other countries the most powerful agency for sickness prevention, Health Insurance?

The share of industry in causing sick-

ness is well recognized. Not only the more clearly defined industrial diseases like lead poisoning and caisson sickness, but also general diseases, tuberculosis, anemia, digestive and nervous disorders, are partly or wholly caused by dust, speeding up, monotony, long hours, or other conditions associated with modern business. Aside, therefore, from the advantage of interesting the employer financially in decreasing sickness by improving working and living conditions, and from his gain by a healthier working force, there is ample justification in requiring industry as such to contribute to the insurance. (Secs. 22-24.)

No new burden will be imposed on the employees. Investigators for the United States Bureau of Labor Statistics and for private institutions agree that at least 4 per cent of the income of working class families goes for care of sickness or for burial insurance. Based on German experience, as noted hereafter, this would be about the total amount required for all the benefits in this draft, and would be divided among employer, worker and state, so that the results of the insurance would be an actual lowering of the item of cost of sickness and burial in the family budget. Moreover, the benefits obtainable in such a subsidized system are greater than those which the workers' unaided contributions could purchase.

On the assumption that 4 per cent of the wages will be required for the benefits provided in this draft, about what the German experience shows would be necessary, the total contributions for a man earning $600 would be $24 a year, or $2 a month. He

would pay 80 cents a month, the employer 80 cents, the state 40 cents. Most mine hospital funds charge the employee $1 a month for medical attendance for sickness and trade accidents alone, usually including his family. (Secs. 23, 24.)

The plan of decreasing the employee's contribution as his wages decrease is adopted from the British act. The argument that his contribution would be no new burden on the individual employee loses force as wages approach the bare subsistence level, and it is therefore only reasonable that the industries which pay extremely low wages should bear an increasing share of the burden of sickness which often results directly from insufficient nourishment or poor housing. Section 22 will decrease the employees' contribution, normally 50 per cent of the joint contribution of employer and employee, by 10 per cent for each decrease in earnings of $1 a week below $9.

If the insurance rate for each industry is not to be based on individual examination of employees, clearly impossible in a large compulsory system, there are three elements which would fix the cost of health insurance. One is age, a second the character of work, and a third, locality. This last element need not be considered in a local mutual plan. The first may be disregarded, since the constant influx of young lives will counterbalance those growing older, and, as the insured must go in when young and continue in the insurance, normally, until he is old, his own overpayments in youth will counterbalance his underpayments later in life (only instead of building up the individual reserve fund necessary in private

voluntary insurance, his overpayments will be used to balance underpayments for some older man, and in turn another younger man's surplus will care for his advancing age). The second element is provided for in the draft by allowing the insurance rates for different industries to vary with the sickness ratio in each, and it may be well to go a step further and increase contributions paid by the employer in particular establishments which show a worse sickness ratio than others in the same industry. Where there are special funds for a particular industry, the question of rates takes care of itself; where several industries are associated in a local mutual, the governing board of a mutual, under the supervision of the state, may fix different rates for the different industries.

Section 22. DIVISION OF EXPENSES. The expenses of the funds shall be met by contributions from employees, employers and the state. The state shall contribute one-fifth of the total expenditures for benefits, subject to the provisions of Section 42; one-half of the balance shall be paid by the employer, one-half by the employee, except that if the earnings of the insured fall below $9 a week, the shares of the employer, employee and state shall be the proportion indicated in the following schedule:

If earnings are under	But not under	Employer	Employee	State
$9	$8	48%	32%	20%
8	7	56%	24%	20%
7	6	64%	16%	20%
6	5	72%	8%	20%
5	..	80%	0%	20%

In all cases the contributions shall be computed as a percentage of wages.

Section 23. AMOUNT OF CONTRIBUTIONS. The amount of the contributions shall be computed so as to be sufficient for the pay-

ment of benefits and the expenses of administration of the fund and necessary reserve and guarantee funds.

Section 24. RATES OF CONTRIBUTIONS. In funds in which employees in several industries are insured, the percentage rates of contribution may be different for different industries, according to the sickness experience.

INSURANCE CARRIERS

The principle of compulsion accepted, the insurance may be carried in any one of three ways: (1) by a state fund managed entirely by the state, as are workmen's compensation funds now existing in several states; (2) by approved societies, as in England; or (3) by district mutual associations, as in Germany. In case of either the first or the third, a place could be made for voluntary societies, and in the second a state organization of some sort would be necessary to cover the persons refused by or refusing to join the approved societies. The draft adopts the district mutual fund as the normal carrier, to which all insured persons must belong unless they are members of an approved voluntary society. This plan provides the most effective organization for combining employers and employees in a campaign for sickness prevention, and a most convenient and practical means for fixing rates and administering benefits. (Secs. 25-28.)

The state fund is open to both positive and negative objections. Its vast detail, the number of its officials, the very large sums of money which would be distributed among individuals insured, physicians, and supply dealers, the opportunity to favor industries, individual plants, and more especially localities, in fixing rates or paying benefits,

would not only make its operation cumbersome and costly but would afford rich opportunities for political favoritism and log rolling. Negatively, the state fund would not develop the sense of responsibility of the people in each locality for the sickness of their district; it would not bring home to each employer and employee the consideration that the less the sickness and the less the fraud, in town or city or industry, the less would be his contributions or the greater his benefits; it would not create a strong local organization, locally responsible and well supplied with money to fight the causes of disease. The advantages of a state fund, the wider outlook of the larger organization with resultant better information as to means of prevention and of cure, the power to compel backward communities to keep up with the progress of sanitation, the coordination of effort of several localities in removing a cause of infection common to all, or greater ease in suppressing such a cause of infection situated in a locality other than that in which the result is felt, prevention of local oppression, coordination of effort in the betterment of legislation, readier exercise of the state's police power, will all be gained by the state Commission provided for in the draft.

Administration by approved societies is open to the negative objections urged against the state fund, and to many that are positive. It is not worth considering in the United States, at all events, until evidence, at present lacking, is brought forward to show that there exists a frame work of voluntary societies, fraternals, trade unions, establishment benefit funds, strong enough

and widely enough extended to support the insurance. Other objections to this method of administration are the consequent multiplication of accounts, difficulties of administration, and supervision of the societies, objections on the part of the societies to state supervision, both in the granting of benefits and management of funds, and the necessity for a separate organization for medical relief which would divorce the physicians from any relation with the insurance carriers; all tending to complicate a system that should, as far as possible, be simplified.

While in the plan adopted local funds including in their membership all the insured persons in the district are the normal carriers, funds for various trades are provided to meet conditions in cities in which the large number of employees in each of several trades forms a sufficient basis for insurance. This plan will make the various mutuals less cumbersome, and will automatically take care of the troublesome question of the varying contributions among industries, according to their various rates of sickness. All funds are democratically governed by the contributors—employers and employees—whose relative representation in the governing boards is proportioned to the amount of their contributions. The members of the fund, employers and employees, elect, each for their own class, the members of a large committee which in turn chooses a board of directors to manage the fund. The large committee serves a double purpose. Because of its size it puts on a great many individuals responsibility for the success of the fund,

and it is a check on the directors, necessarily a small group, who are made responsible to a body which will inquire closely into their administration, instead of to the vague, general meeting of all members, frequently impossible to assemble on account of numbers and never effective. The system is adopted from the German law, and is similar to the ordinary procedure of large corporations in which the large representative powers of directors are often delegated to an executive committee responsible to them, the directors themselves retaining only general administrative supervision of the business. (Secs. 29-34.) A place is made in the plan for labor unions, fraternals, or establishment funds, which are willing to pay at least the minimum benefits provided for, can show that they are democratically managed, are not run for profit, and are financially sound. Employers are not required to contribute to labor unions or fraternal societies, but the state's 20 per cent contribution is given to them. (Secs. 38-40.)

When several societies or several funds are operating in a single district they may combine in a health insurance union for the administration of the medical benefit. This arrangement is necessary both in the interest of an efficient and economical administration of the medical benefit, and to secure the union that is strength in the local campaign for sickness prevention. (Sec. 41.)

A guarantee fund is provided as a sort of reinsurance for extraordinary losses. A great flood, an unusual epidemic, would impose a heavy toll on a local fund at a time when the resources of all of its

contributors were strained to the utmost. The importance of help at such a time would be well worth the small charge necessary to support the fund, a prudent investment from a purely insurance point of view. (Sec. 42.)

Section 25. DIVISION OF THE STATE INTO DISTRICTS. The Commission shall, within six months after this act goes into effect, divide the state into districts, no one of which shall contain less than five thousand persons subject to compulsory insurance; and shall establish one or more local or trade funds in each district.

Section 26. AUTHORIZATION BY COMMISSION. No fund shall begin business until it is authorized by the Commission. The Commission shall authorize a fund only after approval of its constitution and after the names and addresses of the board of directors elected for the first year have been filed with the Commission.

Section 27. POWERS OF FUNDS. Funds shall have all the power necessary to the carrying out of their duties under this act.

Section 28. CONSTITUTION OF FUND. Subject to the provisions of this act, the constitution of a fund shall contain:

Name of the fund and location of its principal office;

If the fund is a trade fund, designation of the trade or trades for which it is created;

Maximum percentage of wages in each occupation at which the regular contribution may be fixed;

Nature and amount of benefits and length of time during which they shall be given;

Manner of election, number, powers, duties, and time of meeting of the committee;

Number, powers, duties, and time of meeting of the board of directors;

Method of amendment of constitution;

ıd such other provisions as may be directed by e Commission.

Section 29. COMMITTEE OF THE FUND. There shall be a committee of each fund which shall consist of not less than twenty and not more than one hundred members, to be elected annually in the manner provided in the constitution, one-half by and from the employer members of the fund, one-half by and from the employee members. The committee shall pass upon the annual account and report submitted by the directors.

Section 30. EMPLOYERS' VOTES. Each employer member shall have as many votes for employer members of the committee as he employs workmen subject to the insurance and members of the fund, except that no one employer shall have more than 49 per cent of the total vote cast by employers unless otherwise provided in the constitution.

Section 31. BOARD OF DIRECTORS. The board of directors shall be elected by the committee for a period of one year. All directors must be citizens of the United States. The board shall consist of not less than eight and not more than eighteen directors, one-half of whom shall be elected by employer members of the committee, and one-half elected by employee members of the committee. No one shall be a member of the committee and a director at the same time. The compensation of members of the board shall not be more than $5 a day for each day of attendance upon the meetings of the board.

Section 32. RESERVE. Every local or trade fund shall accumulate a reserve. The board of directors shall transfer to such reserve one-twentieth of the annual income of the fund until such reserve is equal to one-sixth of the total expenditures for the preceding three years. The reserve shall be maintained at this level. Any surplus which may accrue from the investment of such reserve may be transferred into the general account of the fund.

Section 33. PAYMENT OF CONTRIBUTION. Every employer must pay to any local or trade fund on the date on which he pays his men, or at least monthly, the total contributions due from him and from his employees to such

fund. He may deduct the sum paid as contribution due from each employee from his wages, but must inform him, in a method to be approved by the Commission, of the amount so deducted.

Section 34. MEMBERSHIP IN FUND. Every person subject to insurance shall be an insured member of the trade fund of the trade at which and in the district in which he is employed; or if there be no such fund, of the local fund of such district; provided that while he is a member of an approved society he shall be excluded by the board of directors from membership in the fund. The Commission shall provide by regulation for the case of persons regularly occupied at one trade but temporarily employed at another. Membership in a local or trade fund shall cease as soon as the insured becomes a member of another local or trade fund. Any employer shall be an employer member of all funds of which any of his employees are members.

Section 35. VOLUNTARY INSURANCE. A person entitled to voluntary insurance must be admitted on application to membership in the trade fund of his trade in the district in which he is employed, or if there be no such fund, then in the health fund of such district: Provided, That, except for persons who have been compulsorily insured members within the last twelve months, the by-laws of any fund may prohibit the admission to voluntary insurance of a person who has not passed a satisfactory medical examination by its medical officers, and that the application for admission be subject to the same condition as an application for ordinary life insurance. The contribution of the voluntary member shall be equal to the contribution required of the employer and employee for a compulsory member of the same trade and earnings.

Section 36. LOSS OF VOLUNTARY MEMBERSHIP. A person voluntarily insured loses his membership if he acquire membership, either voluntary or compulsory, in another fund or society, or if he be in arrears for one month in the payment of his contributions, unless this period be extended by the constitution.

Section 37. FINES AND PENALTIES. Funds may fine their employer and insured members and suspend insured members from benefit for violation of their rules or regulations or for fraudulent representations made with the intent of securing or aiding another to secure benefits, in accordance with rules approved by the Commission providing for such fines or suspensions. If an employer fail or refuse to pay the contribution which he is required to pay under this act the carrier to whom they are due may recover the whole sum with interest at 6 per cent by suit in a court of competent jurisdiction, and the employer shall not be entitled to deduct any part of the sum from the wages of his employee or employees.

Section 38. APPROVED SOCIETIES. A labor union, benevolent or fraternal society or an establishment society shall be approved by the Commission only after hearing the local or trade funds affected and only if:

It is not carried on for profit, but reasonable salaries paid officials shall not be considered profit;

It is under the absolute control of the insured members in so far as the insurance regulated by this law is affected, except that the employer may appoint one-half of the governing body of an establishment society;

It shall satisfy the Commission that it is in a sound financial condition.

It grants at least the minimum benefits provided in this act;

It has a membership of at least five hundred persons insured for at least the minimum benefits provided under this act or their equivalent, except that in the case of establishment societies in which the employer satisfactorily guarantees the payment of benefits, the number of members may be fixed by the Commission;

Its operation will not, in the opinion of the Commission, endanger the existence of any local or trade fund;

In case of an establishment society, a ma-

jority of the employees subject to insurance request approval, and the employer's contribution is at least equal to that of all the employees.

The approval of the Commission may be withdrawn at any time upon its finding, after hearing the society affected, that any of the required conditions are no longer satisfied. The Commission may, after a hearing, permit an establishment society to accept, on conditions satisfactory to the Commission, as members all persons subject to insurance in its district.

Section 39. EMPLOYERS' CONTRIBUTIONS. The Commission shall assess, upon every employer any of whose employees are insured in labor union, benevolent, or fraternal societies, a sum equivalent to the employers' contributions had such employees been members of funds. This sum shall be paid in monthly instalments into the guarantee fund established by the Commission.

Section 40. STATE CONTRIBUTIONS. The state shall contribute to every approved society one-fifth of its total expense for benefits and for the expense of Health Insurance under this act, subject to the provisions of Section 42.

Section 41. HEALTH INSURANCE UNION. Two or more health insurance carriers within a district may combine for the administration of the medical benefit subject to the approval of the Commission. The Commission may, after notice to and hearing of the parties of interest, withdraw its approval and dissolve the union, making such disposition of its property as may seem to it in the best interests of the insured.

Section 42. GUARANTEE FUND. The Commission shall reserve 10 per cent of the contributions of the state to the carriers and pay it into a fund to be known as the guarantee fund, from which it shall contribute for the relief of any carrier on the application of its board of directors after investigation by the Commission. A contribution shall be made only where, in the judgment of the Commission, the necessity arises from epidemic, catastrophe, or other unusual con-

ditions, and shall never be made where, in the opinion of the Commission, the deficit is due to failure or refusal of the directors to levy proper rates of contributions. When and as long as, in the opinion of the Commission, the guarantee fund is sufficient, the Commission shall make no reservation for this purpose.

STATE SUPERVISION

The duties of the public administrative authority under the draft will be principally judicial and supervisory. Its purely administrative functions will be few. It is probable that in some states adequate supervision can be developed under existing administrative bodies, such as those administering workmen's compensation, while in other states a non-partisan commission of several members, with terms expiring at different times, may be desirable. (Secs. 43-51.)

A social insurance council formed of elective representatives of employers and employees is joined to the Commission in an advisory capacity. An independent body of experienced men is thus provided to advise the public authority, but it has no power to obstruct or delay the execution of the Commission's orders. Its participation on the judicial side will lighten the work of the commissioners and will provide the element of non-partisan, technical knowledge so important for both just and prompt decisions. This sharing in the administration by these men directly concerned in the insurance as beneficiaries and contributors will increase their interest and their knowledge of its operation, will make the administration more surely mutual and diminish the danger from political or selfish ambitions. The method of election of councillors is in-

expensive and will insure a more careful judgment as to qualifications of candidates than a general election by all persons in the insurance. (Secs. 52-55.)

Section 43. STATE SOCIAL INSURANCE COMMISSION. A state Social Insurance Commission is hereby created, consisting of three commissioners, to be appointed by the governor, one of whom shall be designated by the governor as chairman, and one of whom shall be a physician. The term of office of members of the Commission shall be six years, except that the first members thereof shall be appointed for such terms that the term of one member shall expire on January first, nineteen hundred and eighteen; one on January first, nineteen hundred and twenty, and one on January first, nineteen hundred and twenty-two. Each commissioner shall devote his entire time to the duties of his office, and shall not hold any position of trust or profit, or engage in any occupation or business interfering or inconsistent with his duties as such commissioner, or serve on or under any committee of a political party. The Commission shall have an official seal which shall be judicially noticed.

Section 44. SECRETARY. The Commission shall appoint and may remove a secretary, at an annual salary of ———. The secretary shall perform such duties in connection with the meetings of the Commission and its investigations, hearings and the preparation of rules and regulations under the provisions of this act, as the Commission may prescribe.

Section 45. OFFICERS AND EMPLOYEES. The Commission may appoint such officers, other assistants and employees as may be necessary for the exercise of its power and the performance of its duties under the provisions of this act, all of whom shall be in the competitive class of the classified civil service; and the Commission shall prescribe their duties and fix their salaries which shall not exceed in the aggregate the amount annually appropriated by the legislature for that purpose.

Section 46. SALARIES AND EXPENSES. The chairman of the Commission shall receive an annual salary of ——— and each other commissioner an annual salary of———. The commissioners and their subordinates shall be entitled to their actual and necessary expenses while traveling on the business of the Commission. The salaries and compensation of the subordinates and all other expenses of the Commission shall be paid out of the state treasury upon vouchers signed by at least two commissioners.

Section 47. OFFICES. The commission shall have its main office in the capitol of the state and may establish and maintain branch offices in other cities of the state as it may deem advisable. Branch offices shall, subject to the supervision and direction of the Commission, be in immediate charge of such officials or employees as it shall designate.

Section 48. POWERS OF INDIVIDUAL COMMISSIONERS. Any investigation, inquiry or hearing which the Commission is authorized to hold or undertake may be held or undertaken by or before any commissioner, and the award, decision or order of a commissioner when approved and confirmed by the Commission and ordered filed in its office shall be deemed to be the award, decision, or order of the Commission. Each commissioner shall, for the purpose of this act, have power to administer oaths, certify to official acts, take depositions, issue subpoenas, and compel the attendance of witnesses and the production of books, accounts, papers, records, documents and testimony.

Section 49. POWERS OF COMMISSION. The Commission may adopt all reasonable rules and regulations and do all things necessary to put into effect the provisions of this act.

Section 50. JURISDICTION OF COMMISSION TO BE CONTINUING. The power and jurisdiction of the Commission over each case shall be continuing, and it may, from time to time, make such modification or change with respect to former findings or orders thereto as in its opinion may be just.

Section 51. REPORT OF COMMISSION. Annually on or before the first day of February the Commission shall make a report to the governor, which he shall lay before the legislature, which shall include a statement of the apportionment of the state contribution, statistics of sickness experience under this act, a detailed statement of the expenses of the Commission, the condition of the state guarantee fund, together with any other matter which the Commission deems proper to report, including any recommendations it may desire to make.

Section 52. SOCIAL INSURANCE COUNCIL. The social insurance council shall consist of twelve members, six of whom shall be elected by employer directors of the local and trade funds and six by employee directors of the local and trade funds; their term of office shall be two years, except that in the first election three of the employer and three of the employee members of the council shall be elected for one year; they shall receive a compensation of———a day for each day spent on the business of the council and shall be reimbursed for reasonable expenses.

Section 53. OFFICERS OF COUNCIL. The council shall elect a president from its own number; the secretary of the Commission shall act as the secretary of the council.

Section 54. MEETINGS OF COUNCIL. The council shall meet during the first week of December, of March, of June, of September, each year. Special meetings shall be called by the president on the request of at least five members of the council or of two members of the Commission, at any time.

Section 55. DUTIES OF COUNCIL. The annual report and recommendations of the Commission shall be laid before the December meeting of the council before transmission to the governor, and the council may approve them or make a separate report and recommendations to the governor. All general regulations proposed by the Commission shall be laid before the council at a regular or special meeting for dis-

cussion before final adoption, except in cases of urgency, to be determined by the Commission, and in this case the regulation shall be laid before the next regular meeting of the council or a special meeting called for the purpose.

Section 56. MEDICAL ADVISORY BOARD. The state medical societies shall choose a medical advisory board which shall be consulted on medical matters.

Section 57. SETTLEMENT OF DISPUTES. All disputes arising under the act, except those provided for in Sections 14 and 58, shall be determined by the Social Insurance Commission either on appeal from the proper authority or from the carrier or, in case of disputes between carriers, by original proceedings. The Commission may assign any dispute for hearing and determination to a dispute committee composed of one employer and one employee member of the council, and a member of the Commission, as chairman, the members of the council to serve in turn on the dispute committee for periods of one month; either party may appeal from the decision of the dispute committee to the Commission within thirty days from the date of rendering the decision.

Section 58. MEDICAL DISPUTES. All disputes regarding medical benefit which have been appealed to the Commission shall be referred by the Commission to the medical advisory board which shall report to the Commission and the Commission shall not decide any such dispute until after a report has been made by the board.

Section 59. SUITS AT LAW. Suit shall not be brought in any court on any matter on which an appeal is allowed to the Commission, until after a decision by the Commission or of a dispute committee, and the statutes of limitations shall not begin to run in such cases until after decision of the Commission or dispute committee is filed.

SELECT CRITICAL BIBLIOGRAPHY
ON
HEALTH INSURANCE

The following select list of books and articles on Health Insurance is intended to serve two purposes. It attempts to indicate short, authoritative articles on the important phases of the question for those who in a limited time wish to gain a general idea of this growing movement. In addition the attention of the student and specialist is directed to the more important collections of materials from which he may learn the way to technical and detailed studies. Throughout an effort has been made to choose the titles which are most readily accessible in America.

American association for labor legislation. Brief for health insurance. (American labor legislation review, June 1916, v. 6: 155-226.)

Points out extent and cost of illness among wage-earners, insufficiency of existing measures of protection and insurance, and appropriateness of compulsory health insurance.

.....Health insurance: standards and tentative draft of an act. New York, American association for labor legislation, 1916. 32 p. 3 ed. (Also American labor legislation review, June 1916, v. 6: 237-268.

Brief statement of the need for health insurance and detailed explanation of the association's standard bill, section by section.

.....Select critical bibliography on health insurance. (American labor legislation review, June 1916, v. 6: 269-275.)

Brief collection of most helpful and most available references.

American medical association. Judicial council. Excerpts from the report of the judicial council submitted to the house of delegates at San Francisco, June 21, 1915. (American medical association bulletin, May 15, 1915, v. 10: 341-396.)

Report on development of all branches of social insurance, statistics, scale of benefits, and effect on medical profession.

.....Report of committee on social insurance. (Journal of the American medical association, June 17, 1916, v. 66, no. 25: 1951-1985.)

Summary of operation of health insurance legislation in Europe, need in America, and problems arising, from physician's point of view.

Andrews, John B. Health insurance and the prevention of tuberculosis. (Medical record, Feb. 26, 1916, v. 89: 370-372. Also reprint.)

Health insurance said to be "the most potent means of preventing illness, and especially tuberculosis."

.....Health insurance. (Proceedings, National society for the study and prevention of tuberculosis, 1916.)

Inevitableness of health insurance, provisions of standard bill, and demonstrated efficacy of this method of stimulating preventive and curative work.

.....Physical examination of employees. (American journal of public health, August, 1916. Also reprint.)

Opposition of organized labor to medical examination will disappear only with the introduction of a system of compulsory health insurance to care for the sick while they are being made well. Benefits and extent of the practise.

Austria. Amtliche Nachrichten des k. k. Ministeriums des Innern, betreffend die Unfallversicherung und die Krankenversicherung der Arbeiter. Vienna, 1889-

This series contains the annual reports on the operations of the health insurance system.

Belgium. Ministere de l'industrie et du travail. Brussels, 1896-

Gives summaries of operation of various classes of health insurance funds, e.g. miners, railways, etc.

Bernhard, Ludwig. The future of social policy in Germany, translated by Louis H. Gray. New York, 1912. iv, 19 p. (Published originally in Stahl und Eisen, April 18, 1911, v. 32: 641-649.)
Opposes the policy of legal protection for the workers, especially through social insurance.

Brauchart, ——. Zur Frage der Belastung der deutschen Industrie durch die Arbeiterversicherung. (Zeitscrift für die gesamte Versicherungs-Wissenschaft, July 1, 1914, v. 14, no. 4: 475-492.)
The growth of German industry and the low cost of all social insurance contributions proves that the system has not unduly burdened industry.

Brodsky, Randolph D. Is the German industrial insurance system a failure? A reply to Dr. Friedensburg. (Survey, May 4, 1912, v. 28: 233-238.)
Criticism of Dr. Friedensburg's attack on the German social insurance system.

Burnham, A. C. A plan for the care of the insured under the proposed health insurance law. (Medical record, April 22, 1916, v. 89, no. 17: 737-739.)
Plan for a state health service in charge of local "medical centers" and hospitals.

Cabot, Richard C. Better doctoring for less money. (American magazine, April 1916, v. 81, no. 4: 7-9; 77-78.)
Need of reorganizing medical practise to provide more adequate service through groups of specialists connected with hospitals.

Carr, A. S. Comyns, Garnett, William Hubert Stuart, Taylor, J. H. National insurance. London, Macmillan, 1913. xliii, 1284 p. 4 ed.
Contains text of the British act, explanation of legal difficulties and text of many regulations, orders, decisions, etc.

Chamberlain, Joseph P. Constitutionality of health insurance. (Appendix I in Rubinow, Standards of health insurance.)
Justifies compulsory contributory measure as a reasonable exercise of the police power in behalf of the public health.

.....The practicability of compulsory sickness insurance in America. (American labor legislation review, March, 1914, v. 4: 49-72.)
Practicability affirmed, because a beginning has already been made through establishment funds, commercial insurance, etc. Essential features of state insurance.

Chandler, W. L. Sickness benefit funds among industrial workers. (American labor legislation review, March, 1914, v. 4: 73-81.)
Rates of benefit, methods of management, etc., of establishment funds, based on investigation of over a hundred funds. Suggestions on their possible relation to compulsory insurance.

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27b

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No. 3: Report of the General Administrative Council, 1909.*

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